# Applied Behavioral Analysis (ABA) Treatment Request Form

AmeriHealth Caritas Louisiana

Please print clearly. Incomplete or illegible forms will delay processing. Please return the completed form to AmeriHealth Caritas Louisiana's Behavioral Health (BH) Utilization Management (UM) team at **1-855-301-5356**. For assistance, please call **1-855-285-7466**.

| **Member information** | |
|---|---|
| Patient name: | Legal guardian: |
| Member date of birth: | Medicaid/health plan #: |
| Last authorization # (if applicable): | |

| **Provider information** | | |
|---|---|---|
| Group/agency name: | ☐ In network ☐ Out of network ☐ In credentialing process | |
| Provider name: | Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech | |
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| Physical address: | Phone number: | Fax number: |
| Medicaid/provider/NPI #: | Contact name: | |

| **DSM diagnosis:** | | |
|---|---|---|
| Primary Dx: | Secondary Dx: | Medical Dx: |

**Assessment and clinical documentation requirements:**

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to AmeriHealth Caritas Louisiana BH UM for a medical necessity determination. Failure to submit all clinical documentation may result in a delay of processing this request.

1. Functional Behavioral Assessment.
2. Full Behavior Support Plan/Treatment Plan (including symptoms/behaviors requiring treatment, specific treatment interventions, and that these were indicated by the assessment tool).
3. ABA Therapy Progress Summary including cumulative graphs of progress/standard celebration charts.
4. Sample schedule of treatment.
5. Documentation of caregiver goals, involvement in treatment, and progress in skill development.

Additional information included: _____

List any other services the member is receiving, including service names/therapy, number of hours per week of each, and the targets of those treatments and evidence of coordination with school, preschool, or early intervention program, and other therapy providers (coordination that is more than a phone call or notification of enrollment).

**School/preschool/early intervention program:**

| Type of service | Number of hours/week | Behaviors/deficits targeted |
|---|---|---|
| | | |
| | | |

**Other therapies provided:**

| Type of service | Number of hours/week | Behaviors/deficits targeted |
|---|---|---|
| | | |
| | | |

**Summary of contact with other providers:**

**Treatment request:**

Treatment start date:

| ABA services | Units | CPT code | Time frame (weekly/monthly) | Limitation reminders |
|---|---|---|---|---|
| Behavior identification assessment (ABA) | | 0359T | | |
| Observational BH follow-up assessment | | 0360T, 0361T | | |
| Adaptive behavior treatment by protocol | | 3064T, 3065T | | |
| Group adaptive behavior treatment | | 0366T, 0367T | | |
| Adaptive behavior treatment with protocol modification supervision | | 0368T, 0369T | | |
| Family adaptive behavior treatment guidance | | 0370T | | |
| Multiple-family group adaptive behavior treatment guidance without patient | | 0371T | | |
| Adaptive behavior treatment social skills group | | 0372T | | |

## Provider signature

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.

| Provider signature | Credentials | Date |
| --- | --- | --- |