ABA Request for Initial Authorization

Please complete and submit all supporting documentation/diagnostic assessment with this request form

UM Fax: 1-888-656-7501

MEMBER INFORMATION:

Full Name: _____

Address: _____

Telephone #: (_____) _____ DOB: ___ / ___/ ____ Medicaid #: _____

Emergency Contact Person: _____

Emergency Contact Telephone #: _____

AGENCY/PROVIDER INFORMATION:

Agency/Provider name: _____

Phone number: _____

Mailing address: _____

Fax: _____

MIS/TIN #: _____ AHCCCS ID: _____

Agency contact name and phone number/email: _____

Case manager (mid-tier supervisor) contact: _____

Clinical contact name and phone number/email: _____

REQUESTED SERVICES:

Location: _____

CPT codes: _____ Number of hours: _____

START DATE OF SERVICES/AUTHORIZATION REQUEST: From: ____/____/____ To: ____/____/____

REASON FOR REFERRAL:

Please identify the severe challenging behaviors that present a health or safety risk to self or others *or* significantly interfere with home or community activities.

- ☐ Health risk
- ☐ Self-injury
- ☐ Aggression toward others
- ☐ Destruction of property
- ☐ Stereotyped/repetitive behaviors
- ☐ Elopement
- ☐ Severe disruptive behavior

ASSESSMENT TOOL USED FOR DIAGNOSIS AND FINDINGS:

CURRENT ICD-10/DSM-V DIAGNOSES:

SPECIFY ASD DIAGNOSTIC CRITERION MET PER ICD-10/DSM-V:

DATE ASD DIAGNOSIS ESTABLISHED AND BY WHOM: Please include documentation

DEVELOPMENTAL EVALUATION COMPLETED: **Circle:** Yes or No

OT EVALUATION COMPLETED: **Circle:** Yes or No

SPEECH AND LANGUAGE EVALUATION COMPLETED: **Circle**: Yes or No

OTHER EVALUATION & DIAGNOSIS TESTS TO RULE OUT OTHER CONDITIONS COMPLETED: Please include

LIST MEDICATIONS (Please include frequency and dosage): Is the member medication adherent?

MEDICAL ISSUES and OTHER PHYSICAL FACTORS: Please include documentation

- Date and results of last physical exam
- Date and results of last dental exam
- Date and results of last hearing exam
- Date and results of last vision exam

SPECIAL SUPPORT SERVICES (Provided by the school district, regional center or early childhood program): Please describe. If IEP, please include copy.

GOALS (List 2-3 critical behaviors to be the focus of treatment for the next 6 months):

AREAS OF FUNCTIONING EXPECTED TO IMPROVE BY NEXT REVIEW:

For each behavior, please provide the following:

- Define behavior-
  - Frequency (hourly/daily/weekly)
  - Duration (seconds/minutes/hours)
  - Intensity (1=low: 10=severe)
- Baseline data- include events, situations, circumstances and environmental factors
- History of behavior