Initiation and Continuation of Applied Behavior Analysis (ABA) Therapy Form

Requests for continuation of ABA services must be submitted at least once every six months.

Member Name: ________________________ Date of Birth: ____________

Member ID: ____

Subscriber Name: ____

Members Phone Number: ____

Provider Name: ____

Address: ____

City: ________________________ State: _______ ZIP Code: ____________

Phone Number: ____________________ Fax Number: ____________________

Provider ID, NPI Number, or Tax ID : ________________________________

Member's Diagnosis (please provide diagnostic confirmation like diagnostic reports, doctor's orders, etc.): ________________________________

Severity Level: Level 1 Level 2 Level 3

ABA Treatment History

Initial/First Date ASD Diagnosed: ____

Has this member had ABA services with any other provider?

Yes No If yes, first ABA treatment start date? ________________________

Intensity of these services?

Focused Comprehensive Average number of hours/week __________

Has the member had continuous ABA services since beginning them?

Yes No

Explain any gaps in services and dates?

List accomplishments from prior ABA services:

Goals

Please provide measurable goals that will define improvement.

Existing goals with progress:

New proposed goals:

Parent/caregiver involvement:

The hours per week authorized aren't inclusive of other services being provided (e.g. occupational therapy, physical therapy)

If this request is for a continuation of ABA therapy already started, ABA therapy already started:

Does the individual exhibit symptoms or behaviors that prevent them from participating in age-appropriate home, school or community activities? Explain:

Does the individual exhibit symptoms or behaviors that prevent them from participating in age-appropriate home, school or community activities? Explain:

Has measurable progress been made toward goals and are they documented in the member's treatment plan?

Yes No, explain:

Can progress be maintained if ABA therapy is reduced or discontinued?

Yes No, explain why:

Complete this section for Initiation/Continuation of Treatment for ABA Therapy Services

Certification Period (six months/26 weeks authorization period)

Start date:_______________________________ End date: ______________________________

Code	Service Description	Hours per Week

Clinical justification for increase in hours of service:

If concurrent, ________________ hours were approved during the last

authorization period; ________________ hours used by the member.

Provider's Signature: ____________________________________ Date: ________________

Provider's Printed Name: ____

Credentials: ____

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717, option 2**, or contact your eBusiness Network Manager.

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