Aetna
Fax: 855-225-4102

Sunflower
Fax: 844-824-7705

United
Fax: 888-541-6691

AUTISM (NON-WAIVER) PRIOR AUTHORIZATION REQUEST FORM

Please print clearly and fill out entire form even if the information is documented in attachments. Incomplete or illegible forms will be returned.

MEMBER INFORMATION		**DIAGNOSTIC & TREATMENT INFO**
Member Name:		Primary Diagnosis (Required):
Medicaid ID#:		Date of Initial Diagnosis:
Date of Birth:	Age:	Standardized Assessments Utilized:
Phone Number:	Gender: ❒ M ❒ F	

PROVIDER INFORMATION

Provider Name:	Group Facility Name (If applicable):
Tax ID:	Provider NPI:
Provider Address:	Contact Name:
Phone Number:	Fax Number:
Is this an initial request for authorization? ❒ Yes ❒ No	Is this an annual review? ❒ Yes ❒ No
Date services initiated:	

AUTISM (NON-WAIVER) SERVICES

Codes	**Services**	**Dates of Services Requested**	**Units Requested**
Assessment	**Consultative Clinical & Therapeutic Services (CCTS)**		
97151	Behavioral Identification Assessment – per 15 minutes		
97152	Behavioral Identification Supporting Assessment – per 15 minutes		
Treatment			
97155	Adaptive Behavior Treatment with protocol modification – per 15 minutes		
97156	Family Adaptive Behavioral Treatment – per 15 minutes (limit 4 per day)		
	Intensive Individual Supports (IIS)		
97153	Adaptive Behavioral Treatment by Protocol – per 15 minutes		

Rendering Provider Signature: _____Date: _____

By signing the above, I attest that all individuals rendering service under the proposed treatment plan have the appropriate training and education required to render services.

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ADDITIONAL INFORMATION REQUIREMENTS

Please submit the information noted below with all treatment requests. If documentation is not received, the requests will be reviewed based on the information available at the time of the review.

- For initial assessment (code 97151 only) please submit: Comprehensive diagnostic information including standardized measures; referral from provider for ABA services that is within one calendar year; KAN Be Healthy recommendation within one year. (A general well-child visit does not meet this. It must also include a developmental screen.)

For initial treatment plan please submit:

(If initial assessment was not requested prior to initial treatment plan, then all items in the initial assessment category also must be included with the initial treatment plan.)

- ☐ Standardized testing showing significant behavioral deficit (i.e, Vineland, ADOS, WISC-R, CARS).
- ☐ Criterion Referenced Skill Based Assessment (i.e. ABLLS, AFLS, VBMAPP, etc.)
- ☐ Description of coordination of services with other providers (school, PT, OT, ST).
- ☐ Proposed treatment schedule including the provider type who will render services.
- ☐ Proposed functional, and measureable treatment goals with expected timeframes which target identified behavior deficits.
- ☐ Proposed plan for parent involvement and training and parent's goals for outcomes.
- ☐ Any medical conditions that will impact outcomes of treatment.
- ☐ Copy of IEP or IFSP if applicable.

For subsequent treatment requests please submit:

- ☐ Objective measures of current status.
- ☐ Objective measures of clinically significant progress towards each stated treatment goal.
- ☐ Updated plan for treatment including updated goals and timeline for achievement.
- ☐ Any necessary changes to the treatment plan.
- ☐ Developmental testing which should have occurred within the first two months of treatment.
- ☐ Annual KAN Be Healthy recommendation for continued services
- ☐ Information older than 30 days will be considered outdated and will not be accepted for review.