UnitedHealthcare Community Plan of Washington

Applied Behavior Analysis (ABA) Treatment Request Form

Please fax this form to **877-217-6068** with your supporting clinical documentation.

Provider information		
Provider facility/group name:		Provider Tax ID number (TIN):
Provider servicing address:		
Provider city, state, zip code:		Provider phone number: (XXX)XXX-XXXX
Provider fax number: (XXX)XXX-XXXX	Provider status: Select	

Designated case supervisor information	
Designated case supervisor name and credentials:	
Designated case supervisor contact number:	Designated case supervisor email:
Designated case supervisor availability for call back (days and times):	

Member information		
Member first name:	Member last name:	Member date of birth (DOB): XX/XX/XXXX
Member address:		
Member city, state, zip code:		Member ID number:

United Healthcare Community Plan

Please list all hours requested per month/week

Note: In-network providers require prior authorization for codes **97153**, **97154**, **97158** and **H2020**. If the provider is out-of-network and being accommodated, all codes require prior authorization.

CPT®/ HCPCS Code	Description	Hours
97151 per 15 min.	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	Number of hours Select
97152 per 15 min.	Behavior identification supporting assessment, administered by 1 technician under direction of a physician or other qualified health care professional, face-to-face with the patient.	Number of hours Select
0362T per 15 min.	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • Administered by the physician or other qualified healthcare professional who is on site • With the assistance of 2 or more technicians • For a patient who exhibits destructive behavior • Completed in an environment that is customized to the patient's behavior	Number of hours Select
97153 per 15 min.	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient.	Number of hours Select
0373T per 15 min.	Adaptive behavior treatment with protocol modification, administered by LBAT and 2 or more CBTs — client exhibits destructive behavior, provided in a customized environment.	Number of hours Select
97154 per 15 min.	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient.	Number of hours Select
97155 per 15 min.	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient.	Number of hours Select
97156 per 15 min.	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s).	Number of hours Select
97157 per 15 min.	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers.	Number of hours Select
97158 per 15 min.	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients.	Number of hours Select
H2020	Intensive Day Treatment Program.	Number of hours Select

Note: Please answer below fields as reflected in the attached supporting clinical documentation.

Current primary DSM-5 diagnosis and code number:	
Who gave the diagnosis?	
Date the diagnosis was given:	
Was the diagnosis a result of a comprehensive diagnostic evaluation (code)?	Yes ☐ No ☐
Other medical or mental health diagnosis:	
Medications:	
Location of services:	Select
Other services child receives:	
Is the member in school?	Yes ☐ No ☐
If yes, what kind of school is member attend?	Select
Hours per week the member is in school:	
Hours per week of other therapeutic activities outside of school (i.e., speech, occupational therapy, OP counseling):	
Is there coordination of care with other providers?	Yes ☐ No ☐ N/A ☐
If yes, please include coordination of care in attached supporting clinical documentation:	
Number of years the member has been in ABA services:	
How long has the member been receiving services at this intensity of services?	
Proposed start date of authorization/notification:	
Proposed end date of authorization/notification:	
What is the severity of communication deficit?	Select

What is the severity of social deficit?	Select
What is the severity of behavior deficits?	Select
What is the severity of destructive, maladaptive behaviors?	Select
Are caregivers involved in treatment?	Yes ☐ No ☐
Please give a brief description of caregiver involvement (i.e., separate training sessions, shadowing in sessions, etc.)	
How many hours per week are the caregivers involved in either sessions or caregiver training?	Select
How would you rate caregivers regarding their proficiency with ABA techniques and working with the individual?	Select

I hereby certify and attest that all the information provided as part of this prior authorization request is true and accurate:

Signature

Date

Printed name and title

PCA-1-22-03110-C&S-WEB_10042022

United Healthcare