



APPLIED BEHAVIOR ANALYSIS (ABA) AUTHORIZATION REQUEST

Use this form for both initial and concurrent requests. Please indicate the type of request, as well as the type of services requested. Include the number of requested units as well as hours per day and hours or days per week as indicated. Please submit the following with this request: (1) Proof of diagnosis (for initial requests) (2) Current symptomatology (3) Summary of progress (for concurrent requests)

Requested Start Date for this Authorization: _____

Request for:

- Initial Assessment Initial Treatment Concurrent Request

Patient's Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Phone Number: _____ Patient's Horizon BCBS NJ Member ID#: _____

Patient's Employer/Benefit Plan: _____

Provider/Supervisor: Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst - Doctoral (BCBA-D)

Name: _____

Behavior Analyst Certification Board (BACB) Certification #: _____

Phone Number: _____

Email Address: _____

Is the BCBA credentialed with Horizon BCBSNJ or any other Blue Cross Blue Shield plan? Yes No

Name of Individual Provider or Group (This should match the name, NPI and TIN on claims)

Name: _____

NPI Number: _____ TIN: _____

Provider Address: _____

City/State/Zip: _____

Phone Number: _____

Email Address: _____

SERVICES REQUESTED

(All units are 15 minutes; 4 units equal 1 hour)

Program Setting and Hours per Week:

- Home _____ Facility/Clinic _____ School _____ Other: _____

(Continues)

Patient's Name: _____ ID#: _____

Assessment/Follow-up Assessment

Behavior identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan.

Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis) and follow-up assessments.

97151: Behavior identification assessment (initial or reassessment) administered by a BCBA. Units are in 15-minute increments.

Units Requested: _____

97152: Behavior identification supporting assessment administered by technician under direction of BCBA, face to face with patient. Units are in 15-minute increments. **Clinical justification required.**

Units Requested: _____

0362T: Behavior identification supporting assessment for severe behaviors administered by a BCBA who is on-site, with the assistance of two or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to a patient's behavior. Units are in 15-minute increments. **Clinical justification required.**

Units Requested: _____

Treatment Planning

H0032: Treatment planning by BCBA. Units are in 15-minute increments, up to 4 units per treatment week.

Units Requested: _____

Direct 1:1 ABA Therapy

97153: Adaptive behavior treatment by protocol administered by technician under the direction of BCBA, receiving 1 hour of supervision for every 5 to 10 hours of direct treatment. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:** _____

97154: Group adaptive behavior treatment by protocol by technician under the direction of BCBA, face-to-face with 2 or more patients. Units are in 15-minute increments.

Hours per day: _____ **Days per week:** _____ **Units Requested:** _____

97155: Adaptive behavior treatment with protocol modification, administered by BCBA. May be used for **Direction of Technician (Supervision)** face-to-face with one patient. Units are in 15-minute increments.

Hours per day: _____ **Days per week:** _____ **Units Requested:** _____

0373T: Adaptive behavior treatment with protocol modification implemented by BCBA who is on -site with the assistance of two or more technicians for severe maladaptive behaviors. Units are in 15-minute increments. **Clinical justification required.**

Hours per week: _____ **Units Requested:** _____

Group Adaptive Behavior Treatment

97158: Group adaptive behavior treatment with protocol modification (**Social Skills Group**) by BCBA, face-to-face with two or more patients. Units are in 15-minute increments.

Hours per day: _____ **Days per week:** _____ **Units Requested:** _____

Family Adaptive Behavior Treatment Guidance (Family Training)

By BCBA, with or without the patient.

97156: With individual family. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:** _____

97157: With multiple family group. Units are in 15-minute increments.

Hours per week: _____ **Units Requested:** _____

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