ABA
Prior Authorization Request
Chart Notes Required

Please fax to 503.850.9398 | Questions call YCCO Customer Service 855.722.8205

Out of Network Benefits or Out of Network Providers must complete the required sections

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	
Address:		

REQUIRED **Contact Information**		
Name:	Phone:	Fax:

Primary Care Physician (PCP):	
Requesting Provider:	TIN#:
Address:	NPI#:
Servicing Provider:	TIN#:
Address:	NPI#:

Do you have an active DMAP #: ☐ Yes ☐ No ☐ In Progress

Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan.

Servicing Facility:	TIN#:
Address:	NPI#:

Do you have an active DMAP #: ☐ Yes ☐ No ☐ In Progress

Note: All DMAP administrative rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan.

Requested Item/Service:

ICD-10 Code(s): (Please attach diagnostic evaluation, treatment plan, and recent progress notes by qualified professional)	CPT Code(s)and Units per CPT Code being requested:

COMPLETE ATTACHED ADDENDUM

Out of Network Benefits/Provider: Non-contracted providers need to request an Out of Network Exception. In the event a provider is unwilling to accept DMAP rates additional documentation supporting the enhanced rate will need to be provided. Please indicate your willingness to accept DMAP rates: ☐ Yes ☐ No

Request must include supporting documentation to substantiate why services cannot be provided by an in network provider/facility. □ New Patient or □ Established Patient | Date Last Seen:

Explanation Required:

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REMINDER: COMPLETE ATTACHED ADDENDUM

ABA Authorization Request Addendum

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 a complete treatment plan with this request.

Patient's Name:_____ **ID#**:_____

Requested Start Date for this Authorization:_____

Request for: ☐ Initial Assessment ☐ Initial Treatment ☐ Concurrent Request

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

Program setting and hours per week: ☐ Home ☐ Facility/Clinic ☐ School ☐ Other:_____

Assessment / Follow-up Assessment

By physician or other qualified health care professional (QHP). 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 physician/QHP. Units are in 15-minute increments; up to 32 units for initial, up to 24 units for reassessment.
Units Requested:_____
In the event of extreme clinical need, requests exceeding the listed maximum number of units must include documentation that clearly supports the additional amount of service being requested. Documentation requirements are cited in OAR 410-172-0770(1)(a-i).

☐ **97152:** Behavior identification supporting assessment administered by technician under direction of physician/ QHP, 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 physician/QHP 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:**_____

Direct 1:1 ABA Therapy

☐ **97153:** Adaptive behavior treatment by protocol administered by technician under the direction of physician/ QHP, 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:_____

☐ **97155:** Adaptive behavior treatment with protocol modification, administered by physician/QHP. 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 physician/QHP 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

☐ **97154:** Group adaptive behavior treatment by protocol by technician under the direction of physician/QHP, face-to-face with two or more patients. Units are in 15-minute increments.
Hours per day:_____ Days per week:_____ Units Requested:_____

☐ **97158:** Group adaptive behavior treatment with protocol modification **(Social Skills Group)** by physician/QHP**,** 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 physician/QHP, with or without the patient.
☐ **97156:** With individual family. Units are in 15-minute increments.
Hours per day:_____ Units Requested:_____

☐ **97157:** With multiple family group. Units are in 15-minute increments.
Hours per day:_____ Units Requested:_____

Team Conference

Team conferences are meant to be a more formal conference of the larger team of professionals involved with the family. These codes would not be used for meetings between ABA staff only.
☐ **99366:** Medical team conference with patient and/or family, and nonphysician health care professionals. Units are in 30-minute increments.
Hours per week:_____ Units Requested:_____

☐ **99368:** Medical team conference with nonphysician health care professionals. Units are in 30-minute increments.
Hours per week:_____ Units Requested:_____