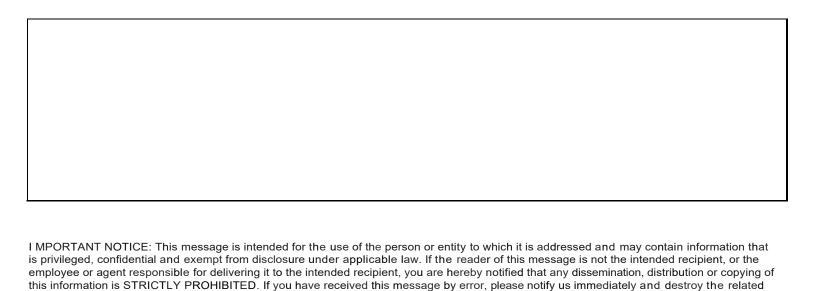


ABA Prior Authorization Request

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 C	PT 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:				



REMINDER: COMPLETE ATTACHED ADDENDUM

message.



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 pl	an mar and requeet.
Patient's Name:	ID#:
Requested Start Date for this Autho	
Request for: □ Initial Assessment	□ Initial Treatment □ Concurrent Request
/A.W	Services Requested
(All unites	s are 15 minutes; 4 units equal 1 hour)
Program setting and hours per weeks	: □ Home □ Facility/Clinic □ School □ Other:
administration of tests, detailed behavior discussion of findings, recommendation Assessment of strengths and weakness Functional Behavior Assessment, Functional Behavior identification assess Units are in 15-minute increments; up to Units Requested:In the event of extreme clinical need, re	are professional (QHP). Behavior identification assessment, oral history, observation, caretaker interview, interpretation, as, preparation of report, development of treatment plan. Sees of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, tional Analysis) and follow-up assessments. Sement (initial or reassessment) administered by a physician/QHP. or 32 units for initial, up to 24 units for reassessment. Equests exceeding the listed maximum number of units must include additional amount of service being requested. Documentation
	rting assessment administered by technician under direction of nt. Units are in 15-minute increments. Clinical justification required.
physician/QHP who is on-site, with the a destructive behavior, completed in an e	rting assessment for severe behaviors administered by a assistance of two or more technicians, for a patient who exhibits nvironment that is customized to a patient's behavior. Units are in ion required. Units Requested:
Direct 1:1 ABA Therapy	

□ 97153: Adaptive behavior treatment by protocol administered by technician under the direction of

minute increments.

physician/QHP, receiving 1 hour of supervision for every 5 to 10 hours of direct treatment. Units are in 15-

Hours per week:	Units Requested:	
•	•	nodification, administered by physician/QHP. May be -to-face with one patient. Units are in 15-minute
Hours per day:	Days per week:	Units Requested:
on-site with the assistant minute increments. Clin	•	nodification implemented by physician/QHP who is for severe maladaptive behaviors. Units are in 15-
physician/QHP, face-to-	e behavior treatment by proto face with two or more patients	col by technician under the direction of . Units are in 15-minute increments Units Requested:
physician/QHP, face-to-	face with two or more patients	tocol modification (Social Skills Group) by . Units are in 15-minute increments. Units Requested:
By physician/QHP, with 97156: With individua	navior Treatment Guidance or without the patient. Il family. Units are in 15-minute Units Requested:	e increments.
•	family group. Units are in 15-m Units Requested:	
with the family. These countries are in 30-minute in	odes would not be used for me conference with patient and/o	iference of the larger team of professionals involved eetings between ABA staff only. r family, and nonphysician health care professionals
increments.	conference with nonphysician Units Requested:	health care professionals. Units are in 30-minute