

**Mississippi Medicaid ABA Treatment Request Cover Form**

Please complete this form and fax to 1-888-541-6691 along with your supporting clinical documents.

In lieu of faxing, you also have the option to submit your authorization request online through [Provider Express](https://electronicforms.force.com/ABATreatment/s/).

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

*(Note: Text fields will expand as needed. You may copy and paste information into fields.)*

*Provider Facility/Group Name:*  Click or tap here to enter text.

*Provider TIN*: Click or tap here to enter text.

*Provider Servicing Address*: Click or tap here to enter text.

*Provider City, State, Zip*: Click or tap here to enter text.

*Provider Phone #*: Click or tap here to enter text.

*Provider Fax #*: Click or tap here to enter text.

*Designated Case Supervisor Name and Credentials*: Click or tap here to enter text.

*Designated Case Supervisor Contact #*: Click or tap here to enter text.

*Designated Case Supervisor Email*: Click or tap here to enter text.

*Designated Case Supervisor availability for call back* (days and times): Click or tap here to enter text.

*Member First Name*: Click or tap here to enter text.

*Member Last Name*: Click or tap here to enter text.

*Member DOB*: Click or tap here to enter text.

*Member Address*: Click or tap here to enter text.

*Member ID#*: Click or tap here to enter text.

| **Please list all hours requested per month/week** | **Telehealth Services** |
| --- | --- |
| **97152** per 15 min | Behavior identification supporting assessment, administered by one technician under direction of a physician or other qualified health care professional, face-to-face with the patient | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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 two or more technicians,
* for a patient who exhibits destructive behavior,
* completed in an environment that is customized to the patient’s behavior.
 | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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 | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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 | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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. | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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).  | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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 | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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.  | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **0373T**per 15 min | Adaptive behavior treatment with protocol modification, 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 two or more technicians,
* for a patient who exhibits destructive behavior,
* completed in an environment that is customized, to the patient’s behavior.
 | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |

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

*Current Primary DSM-5 Diagnosis and Code Number*: Click or tap here to enter text.

*Who gave the diagnosis?* Click or tap here to enter text.

*Date diagnosis was given*: Click or tap here to enter text.

*Was the diagnosis a result of a Comprehensive Diagnostic Evaluation (CDE)?*  Choose an item.

*Other Medical or Mental Health Diagnosis*: Click or tap here to enter text.

*Medications*: Click or tap here to enter text.

*Location of services*: Choose an item.

*Other services child receives*: Click or tap here to enter text.

*Is member in school?* Choose an item.

*If yes, what kind of school is member in?* Choose an item.

*Hours per week member is in school*: Click or tap here to enter text.

*Hours per week of other therapeutic activities outside of school* (e.g., speech, occupational therapy, OP counseling) Click or tap here to enter text.

*Is there coordination of care with other providers?* If yes, please include coordination of care in attached supporting clinical documents: Choose an item.

*Length of time in years member has been in ABA services*: Click or tap here to enter text.

*How long has the member been receiving services at this intensity of services?*  Click or tap here to enter text.

*Proposed Start Date of Authorization/Notification*: Click or tap here to enter text.

*What is the severity of communication deficit?* Choose an item.

*What is the severity of social deficit?* Choose an item.

*What is the severity of behavior deficits?* Choose an item.

*What is the severity of destructive, maladaptive behaviors?* Choose an item.

*Are caregivers involved in treatment?* Choose an item.

*Please give a brief description of caregiver involvement* e.g., separate training sessions, shadowing in sessions, etc.) Click or tap here to enter text.

*How many hours per week are the caregivers involved in either sessions or caregiver training?* Choose an item.

*How would you rate caregivers in regard to their proficiency with ABA techniques and working with the individual?* Choose an item.

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

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| Signature |  | Date |
| Click or tap here to enter text. |  |  |
| Printed Name and Title |  |  |

**For full network and clinical criteria, go to:**

 [**providerexpress.com**](https://www.providerexpress.com/content/ope-provexpr/us/en.html)> Autism/ABA Corner > [**Autism/ABA Information**](https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/autismABA.html) page

Find links on the page to:

* **[Optum Network Manual](https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html)**
* [**Optum ABA Policy**](https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/autismABA/abaSCC.pdf) (Supplemental Clinical Criteria: Applied Behavior Analysis)