

**Ohio Medicaid ABA Treatment Request Cover Form**

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

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 in this form 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** |
| --- | --- |
| **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. | Click or tap here to enter text. hours/ Choose an item. | Choose an item. |
| **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. |
| **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. |

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

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 treatment plan: 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 (i.e., 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 > [**OH Public Health Care Program (OHPHCP) ABA Program**](https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/autismABA/ohMedicaid.html)

* [**Ohio Medicaid ABA Policy**](https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/optumLOCG/ohlocg/ohMedcadLOCG.pdf) (Supplemental Clinical Criteria: Ohio Medicaid)