✓MetroPlusHealth | **APPLIED BEHAVIOR ANALYSIS (ABA) FORM**

SUBMIT VIA FAX TO (212)908-5182 OR EMAIL TO **METROPLUSABA@METROPLUS.ORG**

Please use this Universal ABA request form for initial requests for assessment, as well as initial and concurrent treatment plan requests. All information must be complete.

Please indicate type of request: □ Initial Assessment □ Initial Treatment □ Concurrent Request ☐ Continuity of Care

Member Information:

Name: _____

DOB: _____ Age: ____ □ M □ F □ Other: _____

Phone Number: _____

Insurance ID #: _____

Benefit Plan / Employer: _____

Certification #: _____
(Concurrent review only)

Diagnostic Information:

Diagnosis: _____

Subtype: _____

Specifier: _____

Symptoms: _____

Diagnosed by whom: _____

License#: _____

Date of diagnosis: _____

Please attach Comprehensive diagnostic report for Initial Assessments

Ordering Physician (Please attach MD referral prescription for ABA therapy/current physical):

Physician's Name: _____ License #: _____

Phone: _____ Address: _____

Provider / Agency Information:

Name: _____

Tax ID #: _____

MetroPlusHealth Group ID #: _____

Services Address: _____

_____

Phone Number: _____

Email Address: _____

Rendering Provider / LBA Supervisor:

Name: _____

LBA Credential #: _____

NPI # _____

Phone Number: _____

Provider email: _____

MetroPlusHealth Provider #: _____

Initial Request for Assessment:

Reason for Referral:

Skills Assessment tool(s) to be used:

(i.e., ABLLS-R, VB-MAPP, FBA, etc.)**:**

_____

Assessment and Treatment Plan Requirements

- Treatment plan specific to core behavioral symptoms of autism/skill deficits/behavioral challenges requiring treatment, as identified by the standardized assessment tool. Describe desired outcomes in behavioral and measurable terms, mastery criteria, baseline data, and target mastery date.
- Diagnostic Comprehensive autism evaluation/report
- Family training plan inclusive of goals, level involvement/barriers
- Provide an FBA/ Complete Behavior Support Plan (as appropriate)
- Coordination of care with other providers (e.g., OT, PT, Speech, etc.)
- Cumulative graphs of progress with baseline data
- Client specific titration criteria and discharge plan

AUTHORIZATION START DATE: _____

All services are to be rendered by a qualified physician or Healthcare Professional (QHP) as per individual Plan requirements. Where indicated please include the place of service, and number of requested units per week.
All Units are 15 minutes; 4 units equal 1 hour.

CPT Code	Requested Units Per week/Place Of Service	Authorization Request Type	Description	Guidance
97151	Units: _____ POS: _____	Behavior Identification Assessment (initial or reassessment)	By a physician or other qualified health care professional (QHP). Behavior identification, assessment, administration of tests using standardized tools that assess skills across domains, detailed behavioral history, observation, caretaker interview, interpretation and discussion of findings, preparation of report, and development of treatment plan for assessment and reassessment	Up to 32 units max for initial assessments, up to 12 units max for reassessment
97152	Units: _____ POS: _____	Behavior Identification Supporting Assessment	Administered by a technician under the direction of a physician or QHP, face-to-face with patient	Clinical justification required
0362T	Units: _____ POS: _____	Behavior Identification Supporting Assessment for severe behaviors	Administered by a physician/QHP who is on site, with the assistance of 2 or more technicians, for a patient who exhibits destructive behavior, completed in an environment that is customized to the patient's behavior	Clinical justification required
97153	Units: _____ POS: _____	Adaptive Behavior Treatment by Protocol	Administered by technician under the direction of a physician/QHP, receiving 1 hour of supervision for every 5-10 hours of direct treatment	
97154	Units: _____ POS: _____	Group Adaptive Behavior Treatment by Protocol	By technician under the direction of a physician / QHP, face-to-face with two or more patient's	
97155	Units: _____ POS: _____	Adaptive Behavior Treatment with Protocol Modification	Administered by physician/QHP. May be used for Direction of technician, face-to-face	
97156	Units: _____ POS: _____	Family Adaptive Behavior Treatment Guidance	Administered by physician/QHP with individual family, with or without patient present	
97157	Units: _____ POS: _____	Multiple-Family Group Adaptive Behavior Treatment Guidance	Administered by physician/QHP with multiple families in a group, with or without patient present (2-8 sets of caregivers)	
97158	Units: _____ POS: _____	Adaptive Behavior Treatment Group	Administered by physician/QHP, face-to-face with two or more patient's (max 8 members in a group)	
0373T	Units: _____ POS: _____	Adaptive Behavior Treatment with Protocol Modification.	Administered by a physician/QHP who is on site, with the assistance of 2 or more technicians for patient who exhibits destructive behavior	Clinical justification required

Provider's Printed Name: _____ License #: _____

Provider's Signature: _____ Date: _____

My signature confirms that any paraprofessional under my supervision has the appropriate credentials, education, and training.

*Information older than 30 days will not be accepted for continued stay review.