Applied Behavior Analysis (ABA) for the Assessment of Autism Spectrum Disorder

Initiation and Continuation of Applied Behavior Analysis (ABA) Therapy Form

Submit request online through Availity.com or fax to: 1-800-496-9600

Requests for continuation of ABA services must be submitted at least once every 6 months.

Provider of ABA Services Name: ______________________________

Address: ______________________________

City: ______________________ ZIP Code: ____________

Phone Number: ______________ Fax Number: ______________

Provider ID, NPI Number, or Tax ID : ______________________________

Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder

Member Name: ______________________ Date of Birth: ____________

Member Identification Number: ______________________________

Member Parent's/Guardian's Name: ______________________________

Member Current Telephone Number: ______________________________

Diagnosis and Severity Level: ______________________________
Diagnostic confirmation is required. (i.e., Diagnostic report, doctor's order, etc.)

Level 1 Level 2 Level 3

The hours per week authorized aren't inclusive of other services being provided (e.g. occupational therapy, physical therapy).

If this request is for a continuation of ABA therapy already started, does the individual continue to exhibit symptoms/ behaviors that:

Are they a safety risk to self, others or property? Explain:

Prevent adequate participation in age-appropriate home, school or community activities? Explain:

If this request is for a continuation of ABA therapy already started, has measurable progress been made toward goals and are they documented in the member's ABA therapy treatment plan?

Yes No, explain:

If this request is for a continuation of ABA therapy already started, can progress be maintained if ABA therapy is reduced or discontinued?

Yes No, explain why:

ABA Treatment History

Initial/First Date ASD Diagnosed: ____________________

Has this member had ABA services with any other provider?

Yes No If yes, first ABA treatment start date? ____________________

Intensity of these services?

Focused Comprehensive Average number of hours/week ________

Continuous ABA services since start?

Yes No

If break from services, then when and why?

List accomplishments from prior ABA services?

Please provide measurable goals that will define improvement

Existing goals with progress:

New proposed goals:

Parent/Caregiver involvement:

Complete this section for Initiation/Continuation of Treatment for ABA Therapy Services

Certification Period (6 months/26 weeks authorization period)

ABA Therapy will begin:_________________ ABA Therapy will end: _________________

Code	Service Description	Hours per Week

Clinical justification for increase in hours of service:

If concurrent, ________________number of hours were approved during the last

authorization period; ________________number of hours used by the member.

Provider's Signature: ____________________________________ Date:________________

Provider's Printed Name: ____

Credentials: ____

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Contact the eBusiness Marketing team for all your Availity.com registration and/or training needs by calling 423-535-5717, option 2.

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