Applied Behavioral Analysis (ABA) prior authorization form

☐ Check if requesting on behalf of a Cigna-participating provider

Provider information

Provider/agency/practitioner name		Contact name			
Provider tax ID		Phone		Fax	

Member information

Member last name		Member first name	
Priority Health ID#		Date of birth	
Date of initial evaluation*		Evaluation completed by – *name, credentials*	
Testing instrument		Diagnosis	
Start date			
**If more than three years since evaluation, a new evaluation must be completed*			

Request type

☐ Initial authorization request

☐ Continue authorization request
Authorization number: _____

Treatment plan and progress noted – *per ABA standards*
Attach relevant clinical documentation as appropriate.

- Baseline to date progress
- Dates that goals are met
- Date new goals were developed
- Discharge criteria
- School status – *no school, full-time, part-time*
- Hours / sessions of parent training completed

Number of hours that direct treatment was provided during the review period:

97151	**Behavior identification assessment, by a physician or other qualified healthcare professional, per 15 minutes** Time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and nonface- to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	**# of hours requested**
97153	**Adaptive behavior treatment by protocol, per 15 minutes** Administered by technician under the direction of a BCBA, face-to-face with one patient	**# of hours per week**
97154	**Group adaptive behavior treatment by protocol, per 15 minutes** Administered by technician under the direction of a BCBA, face-to-face with two or more patients	**# of hours per week**
97155	**Adaptive behavior treatment with protocol modification, per 15 minutes** Administered by BCBA, which may include simultaneous direction of technician	**# of hours per week**
97156	**Family adaptive behavior treatment guidance, per 15 minutes** Administered by BCBA, with or without patient present, face-to-face with guardian(s)/caregiver(s)	**# of hours per week**

Verify that information is complete and required supporting documentation is included. After a clinician reviews the information, we'll notify you of the determination via phone or fax. Coverage is subject to the member's specific benefits.

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