BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	*ABA Therapy*	*****Prior Authorization is Required*****

Use AuthAccel - **Blue Shield's online authorization system** - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: The Federal Employee Program has a 15 Day turn-around time on all Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Referring/Prescribing Provider:
Name:

Street Address + Suite#:

City, State, Zip:

Tax ID Number: **NPI:**

Contact Name:

Phone: ( ) Fax: ( )

Patient's First Name:

Patient's Last Name:

Patient's Date of Birth:

ID Number Beginning with "R":

Servicing/Billing: Provider/Vendor/Lab
Name:

Address + Suite#:

City, State, Zip

Tax ID Number: **NPI:**

Contact Name:

Phone: ( ) Fax: ( )

Type of provider: ☐ PCP; ☐ Specialist Type:

If Servicing Provider is *billing as part of a Group Contract* enter the Group Name and Address:
Group Name:

Group address + Suite#

City, State, Zip

Tax ID Number: **NPI:**

Billing Facility (If Applicable):
Facility Name:

Street Address

City, State, Zip

Tax ID Number: **NPI:**

Contact Name:

Phone: ( ) Fax: ( )

Anticipated Date of Service:

Place of Service: (Check One Box Only)
☐ Office; ☐ Acute Rehab;
☐ Ambulance- Air or Water; ☐ Ambulance-Land;
☐ Ambulatory Surgical Center;
☐ Assisted Living Facility; ☐ Birthing Center;
☐ Custodial Care Facility;
☐ End Stage Renal Disease Tx; ☐ Group Home;
☐ Home; ☐ Hospice; ☐ Independent Clinic;
☐ Independent Laboratory; ☐ Inpatient Hospital;
☐ Intermediate Care Facility; ☐ IOP;
☐ IP Psychiatric Facility; ☐ Nursing Facility;
☐ Off Campus OP Hosp; ☐ On Campus OP Hosp;
☐ PHP; ☐ RTC – Psychiatric; ☐ RTC – SUD;
☐ Skilled Nursing Facility; ☐ Telehealth;
☐ Urgent Care Facility;
☐ Other - Please Specify

Please enter all codes requested; *unlisted codes must have a description*.
Please include the quantity for each code requested.

ICD-10 CODE(S):

CPT CODE(S):

Fax Number: 1-855-895-3504	Phone Number: 1-800-633-4581

View our Medical Policy on line at https://www.fepblue.org/legal/policies-guidelines

Please provide the following documentation:

Date ABA Services Began: *(Please include initial start of ABA services after initial DX of Autism.)*
What assessment tool was utilized to determine the above DSM-5 diagnosis and date of Dx:

Location of current services: ☐ Home ☐ Office ☐ Community ☐ School ☐ Other:

Is this member currently enrolled in school with an IEP? ☐ Yes ☐No *If "No" please provide rationale why there is no IEP in place. Also, include what the family's plan is to have the member enrolled in school/IEP.*

Criteria to Initiate Care*

Please attach the following information to this request:

- An established and current (within 24 months) DSM-5 diagnosis of Autism Spectrum Disorder using validated assessment AND the scores from the tools utilized to make that diagnosis or ABA therapy within the past 90 days.
- Developmental assessment has been completed within the last 12 months using validated assessment tools (e.g. Vineland, ABAS). Data must be included that demonstrates the standard deviation for each skill area.
- A current care plan that reflects:
    - The caregiver's level of participation in the proposed plan of care
    - Specific, quantifiable goals that relate to developmental deficits or behaviors that pose a significant risk of harm to the recipient or others
    - Objective, observable, and quantifiable metrics that are or will be utilized to measure change toward the specific goal behaviors
    - Collaboration of Care: Documentation that adjunctive treatments (e.g., psychotherapy, social skills training, medication services, educational services, PT, OT, SLP) have been considered for inclusion in the treatment plan, with the rationale for exclusion
    - Discharge Criteria and Transition Plan- *Note: It is imperative that a realistic exit criterion is established. Please factor in all the facets above when creating the transition plan/exit criteria versus non-specific or unrealistic future expectations.*

Criteria for Continued Care*

Follow-up documentation should include:

- Date that ABA therapy was initiated. What services have been provided and at what intensity (hours of service per week)?
- Updated documentation that reflects progress toward goals utilizing objective, observable, and quantifiable metrics.
- Developmental assessment has been completed within the last 6 months using validated assessment tools (e.g. Vineland, ABAS). Data must be included that demonstrates the standard deviation for each skill area and results must reflect that the eligible recipient still cannot participate at an age appropriate level because of the presence of behavioral excess and/or the absence of functional skills.
- Documentation that the recipient's caregivers demonstrate continued commitment to participation in the recipient's treatment plan and demonstrate the ability to apply those skills.
- Documentation that the behavior issues are not exacerbated by the treatment process.
- Documentation that the recipient has the required cognitive capacity to benefit from the care.
- Collaboration of Care: Documentation that adjunctive treatments (e.g., psychotherapy, social skills training, medication services, educational services, PT, OT, SLP) have been considered for inclusion in the treatment plan, with the rationale for exclusion
- Discharge Criteria and Transition Plan- *Note: It is imperative that a realistic exit criterion is established. Please factor in all the facets above when creating the transition plan/exit criteria versus non-specific or unrealistic future expectations.*

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***Current/Proposed Service Schedule**

Time	Day	Location	ABA Goals / Skills Addressed	People Involved to Address Goal

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