Prior Authorization Request Form

ABA (Applied Behavioral Analysis) Use only for Commercial products

Behavioral Health Treatment fax: (844) 742-1155	**Behavioral Health Treatment phone: (844) 729-1416**

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

Blue Shield has a five business day turnaround time on all standard prior authorization requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Important for urgent requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to severe pain, potential loss of life, limb, or major bodily function, and a delay in decision-making might seriously jeopardize the life or health of the enrollee. If there is no MD signature present, the request will be processed as a standard request.

MD signature REQUIRED for urgent requests only:

Type of request: ☐ New standard request ☐ Retro request ☐ Urgent request

If you are submitting a modification or extension, check one, and complete the details below: ☐ Modification request ☐ Extension request

Date last authorized: Previous authorization number:

BCBA justification for modification or extension:

Patient information

First name: Last name:

Date of birth (DOB): Blue Shield subscriber ID number:

Street address: City:

Home phone: State: ZIP code:

Cell phone: Primary: ☐ Home ☐ Cell

Require interpreter: ☐ Yes ☐ No ☐ American Sign Language

Requesting QAS provider

QAS provider first name: QAS provider last name:

Group name: Group tax ID:

Group NPI: Specialist type:

Street address and suite number:

City: State: ZIP code:

Phone number: Fax:

Servicing/rendering QAS provider **If same as requesting QAS provider, check ☐**

QAS provider first name: QAS provider last name:

Group name: Group tax ID:

Group NPI: Specialist type:

Street address and suite number:

City: State: ZIP code:

Phone number: Fax:

Place of service (check one box only):

☐ Office ☐ Home ☐ Telehealth ☐ Community setting

☐ Other (please specify) _____

CPT/HCPC code(s):

Procedure code	97151	97152	0362T	97153	97154
Hours					
Frequency	One time	One time	One time	Week/month	Week/month

Procedure code	97155	97156	97157	97158	0373T
Hours					
Frequency	Week/month	Week/month	Week/month	Week/month	Week/month

Diagnosis: ICD-10 code(s):

*****See patient clinical information box below for required documentation*****

Requested start date of authorization:

Contact name: Contact fax number:

Contact phone: Is the voicemail confidential: ☐ Yes ☐ No

Please include the documentation listed below when you return this form to Blue Shield of California

ABA treatment plan and/or progress report, including:

- ☐ Clear identification of the service type, number of hours of direct service(s), observation and direction, guardian training, support, and participation needed to achieve the goals and objectives, the frequency at which the member's progress is measured and reported, transition plan/criteria, crisis plan, and each individual provider who is responsible for delivering services.
- ☐ Documentation of the type and degree of behaviors needing treatment (including frequency of baseline behaviors).
- ☐ Documentation of the member's baseline skills and problems (functional and skill-based assessments).
- ☐ Clinical findings (i.e., pertinent symptoms and duration).
- ☐ Recent assessments/reports, assessment procedures and results, and evidence-based ABA services.
- ☐ Comorbidities.
- ☐ Demographics: living situation, school, and work information.
- ☐ Summary of clinical interview and direct observation.
- ☐ Proposed/current treatment plan including but not limited to the anticipated response to treatment, goals (date of introduction, estimated date of mastery) and other types of treatment that have been tried (with results) or considered but excluded.
- ☐ Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors.
- ☐ Outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
- ☐ Specify the instruments that will be used (for example: Vineland, BRIEF, SSIS, SR-2, ADOS-2, TOPL-2, ABAS-3, etc.).
- ☐ Discharge plan.
- ☐ Care coordination that involves the guardian, school, state disability programs, and other programs and institutions, as applicable.