Today's date: ______/_______/______
Date range of service requested: ______/_______/______ to ______/_______/______

Applied Behavioral Analysis (ABA) services require one of the following prior authorization Approvals:

- ☐ **Request for initial evaluation** *Submit page 1 with copies of the following*:
  - Individual Education Program (IEP)
  - Comprehensive diagnostic and/or functional assessment completed by a neurologist, pediatrician, psychiatrist, psychologist, or other experience licensed physician
  - If Early Intervention, a valid referral from primary care provider to EI Services and accepted by EI for Intensive Services
- ☐ **Request for continued services** *Submit pages 1-4.*

The Board-Certified Behavioral Analyst (BCBA) rendering the Applied Behavioral Analysis serves should complete this form. We will not approve the request if completed by a non-BCBA provider.

**Member Information**

Name: ____________________________________________ ID#: ____________________
DOB: _____/______/_____ Address: ____________________________________________
____________________________________________
City: ___________ State: ____________ Zip Code: _________

**BCBA Provider Information**

Name: ____________________________________________ NPI#: ___________________
Address: ______________________________________________________________________
City: ___________________ State: ___________________ Zip Code: ________________
Tax ID #: _______________ Phone: _________________ Fax: ____________________
Licensure: _____________________________________________________________________
How many times have you seen this patient? _________ Date if most recent contact: _________

**Requested services** Submission of this form does not guarantee authorization of your request. If your patient is younger than 18, a parent or legal guardian must be present at all treatment visits.

Has the parent or legal guardian committed to being present at all treatment visits?

☐ Yes ☐ No

| Code | Description | # of units requested |
|---|---|---|
| H2014 | Treatment consultation- occupational, physical, speech and language therapists | |
| 2014 HO | Treatment Consultation (Master Level Clinician) | |
| 2014 HP | Treatment Consultation (Doctoral Level Clinician) | |
| H0046 | Lead Therapy | |
| H0046 HO | Clinical Supervision- Home Based or Treatment Support Worker- Master Level Clinician) | |
| H0046 HP | Clinician Supervision- Home based or Treatment support worker- Doctoral Level Clinician | |
| T1013 | Sign language or oral interpreter services, (up to 8 hours per month, 4 for supervision and 4 for parent training, not to be used with direct service) | |
| T1016 | Treatment Consultation | |
| T1024 | Home based therapy-Specialized treatment/treatment support | |

*For Tufts Health RITogether patients, use the modifier HO or HP*

**Clinical information** *Please specify the services your patient has already received.*

- ☐ Individual Education Program (IEP)
- ☐ Individual Service Plan (ISP)
- ☐ Early intervention services
- ☐ Comprehensive diagnostic evaluation
  - Date completed: ______/_______/______
  - Provider who completed the diagnostic evaluation: ________________________
  - Licensure (Please select one of the following):
    - ☐ Neurologist/Pediatric neurologist
    - ☐ Psychiatrist
    - ☐ Psychologist
    - ☐ Developmental pediatrician
    - ☐ Other licensed physician experienced in the diagnosis and treatment

Definitive ICD 10 diagnosis (F code): ___________________________________________________

**Current Treatment** *If requesting continued services, indicate the other providers (e.g., occupational, physical, or speech therapist) involved in your patient's care and any communication with those providers.*

| **Provider and specialty** | **Communication** |
|---|---|
| Provider name: ___________________________ | Date: ______/_______/______<br>Discussion: |
| Specialty: Primary care provider | |
| Provider name: ___________________________ | Date: ______/_______/______<br>Discussion: |
| Specialty: Behavioral health provider | |
| Provider name: ___________________________ | Date: ______/_______/______<br>Discussion: |
| Specialty: Primary care provider | |
| Provider name: ___________________________ | Date: ______/_______/______<br>Discussion: |
| Specialty: Other, please specify | |
| Provider name: ___________________________ | Date: ______/_______/______<br>Discussion: |
| Specialty: Other, please specify | |

Please list the providers, including yourself, from whom your patient has received services.

| **Services Provider** | **Start date** | **End date** |
|---|---|---|
| | ______/_______/______ | ______/_______/______ |
| | ______/_______/______ | ______/_______/______ |
| | ______/_______/______ | ______/_______/______ |

Is your patient receiving any special services at school or in the community? ☐ Yes ☐ No
*If yes, which ones?* ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please describe how your patient's parent or legal guardian participates in treatment sessions

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please describe how your patient's parent or legal guardian participates in treatment sessions

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Current medications** *If requesting continued services, please describe your patient's medication plan.*

Has your patient received a medication consultation? ☐ Yes ☐ No

If yes, by whom? ______________________________________________________________

Is your patient receiving medication? ☐ Yes ☐ No

If yes, please list the medications below:

| Medication | Dosage | Treatment length and patient response | Prescribing provider |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Goals for the next three months** *If requesting continued services, please identify behaviors you are working with your patient to change. Please attach additional pages if needed.*

| Behavior | Date behavior identified | Goal | Current level of functioning | Target completion date |
|---|---|---|---|---|
| *Example: Tantrum when wanting food* | *Example: Feb 1, 2017* | *Example: Request food using the appropriate sign or word* | *Example: Nonverbal, no signs or words for food* | *Example: December 1, 2016* |
| | | | | |
| | | | | |
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| | | | | |

Signature: ______________________________________ Date: ______/_______/______