



Arizona Medicaid ABA Treatment Request Cover Form

Please complete this form and fax to [1-888-541-6691](tel:1-888-541-6691) along with your supporting clinical documentation.

In lieu of faxing, you also have the option to submit your authorization request online through [Provider Express](#).

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

(Note: Text fields in this form will expand as needed. You may copy and paste information into fields.)

Provider Facility/Group Name: Click or tap here to enter text.

Provider TIN: Click or tap here to enter text.

Provider Servicing Address: Click or tap here to enter text.

Provider City, State, Zip: Click or tap here to enter text.

Provider Phone #: Click or tap here to enter text.

Provider Fax #: Click or tap here to enter text.

Designated Case Supervisor Name and Credentials: Click or tap here to enter text.

Designated Case Supervisor Contact #: Click or tap here to enter text.

Designated Case Supervisor Email: Click or tap here to enter text.

Designated Case Supervisor availability for call back (days and times): Click or tap here to enter text.

Member First Name: Click or tap here to enter text.

Member Last Name: Click or tap here to enter text.

Member DOB: Click or tap here to enter text.

Member Address: Click or tap here to enter text.

Member ID#: Click or tap here to enter text.

Please list all hours requested per month/week			Telehealth Services
97151 per 15 min	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97152 per 15 min	Behavior identification supporting assessment, administered by one technician under direction of a physician or other qualified health care professional, face-to-face with the patient	Click or tap here to enter text. hours/ Choose an item.	Choose an item.

Please list all hours requested per month/week			Telehealth Services
0362T per 15 min	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: - administered by the physician or other qualified healthcare professional who is on site, - with the assistance of two or more technicians, - for a patient who exhibits destructive behavior, - completed in an environment that is customized to the patient's behavior.	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97153 per 15 min	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97154 per 15 min	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with the patient	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97155 per 15 min	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient.	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97156 per 15 min	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s).	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97157 per 15 minutes	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
97158 per 15 min	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients.	Click or tap here to enter text. hours/ Choose an item.	Choose an item.
0373T per 15 min	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: - administered by the physician or other qualified healthcare professional who is on site, - with the assistance of two or more technicians, - for a patient who exhibits destructive behavior, - completed in an environment that is customized, to the patient's behavior.	Click or tap here to enter text. hours/ Choose an item.	Choose an item.

Note: Please answer below fields as reflected in the attached supporting clinical documentation.

Current Primary DSM-5 Diagnosis and Code Number: Click or tap here to enter text.

Who gave the diagnosis? Click or tap here to enter text.

Date diagnosis was given: Click or tap here to enter text.

Was the diagnosis a result of a Comprehensive Diagnostic Evaluation (CDE): Choose an item.

Other Medical or Mental Health Diagnosis: Click or tap here to enter text.

Medications: Click or tap here to enter text.

Location of services: Choose an item.

Other services child receives: Click or tap here to enter text.

Is member in school? Choose an item.

If yes was kind of school is member in: Choose an item.

Hours per week member is in school: Click or tap here to enter text.

Hours per week of other therapeutic activities outside of school (i.e., speech, occupational therapy, OP counseling): Click or tap here to enter text.

Is there coordination of care with other providers? If yes, please include coordination of care in attached supporting clinical documentation: Choose an item.

Length of time in years member has been in ABA services: Click or tap here to enter text.

How long has the member been receiving services at this intensity of services: Click or tap here to enter text.

Proposed Start Date of Authorization/Notification: Click or tap here to enter text.

What is the severity of communication deficit? Choose an item.

What is the severity of social deficit? Choose an item.

What is the severity of behavior deficits? Choose an item.

What is the severity of destructive, maladaptive behaviors? Choose an item.

Are caregivers involved in treatment? Choose an item.

Please give a brief description of caregiver involvement i.e., separate training sessions, shadowing in sessions, etc. Click or tap here to enter text.

How many hours per week are the caregivers involved in either sessions or caregiver training? Choose an item.

How would you rate caregivers in regard to their proficiency with ABA techniques and working with the individual? Choose an item.

I hereby certify and attest that all the information provided as part of this prior authorization request is true and accurate:

Click or tap here to enter text.

Signature

Click or tap here to enter text.

Date

Click or tap here to enter text.

Printed Name and Title

For full network and clinical criteria, go to:

providerexpress.com > Autism/ABA Corner > [Autism/ABA Information](#) page > [AZ AHCCCS ABA Program](#)

- [Arizona Policy Manual](#)
- [Arizona ABA Policy](#) (Supplemental Clinical Criteria: Applied Behavior Analysis)