ALABAMA MEDICAID AGENCY
Behavior Assessment and Treatment Request (CPT 97151) for Applied Behavioral Analysis for Autism Spectrum Disorder

This form should be completed by the Board-Certified Behavior Analyst (BCBA) or approved provider who will be rendering and/or supervising the services. Please complete all parts as clearly and as specifically as possible. Lack of descriptions or non-patient specific information could result in denial or delay of review.

Patient Name:	**Patient DOB:**
Recipient ID Number:	**Current Diagnosis Code(s):**
Request Date:	**Diagnosed by/date:**

Billing Provider Name:	**Billing Provider NPI:**
Rendering Provider Name:	**Rendering Provider NPI:**
Address:	**Provider Tax ID:**
Phone:	**Email:**
Fax:	**Contact person:**

Parent/Guardian Name:	**Phone:**
Relationship to Recipient:	**Email:**

If the IEP addresses behavioral plans/interventions/goals that overlap with plans/interventions/goals in the PA, the PA is likely to be denied. If there is an overlap between the PA and the IEP, be sure to indicate how the goals are different (e.g., medical necessity vs. educational necessity). Does the recipient have a current IEP or is s/he currently receiving therapy through school-based services? Yes◯ No◯ If "Yes," please include the entire document when submitting the PA.

Previous ABA treatment/dates/provider/results:

Co-occurring behavioral health and medical diagnoses:

Current symptoms and relevant behavioral and medical history:

Evaluation Findings: *Briefly summarize your findings, including criteria of DSM-5, test scores etc. Briefly summarize findings derived from observation in natural settings such as school and home. Attach other pertinent findings/information to support diagnoses or findings listed below.*

Behavioral Targets/Behavior Disorders and Treatment Plan: *List the targeted behaviors that have an impact on the development, communication, interaction with peers and others in the environment, adjustments to the settings in which the patient's functions have diminished and update the anticipated target date for mastery. All skill acquisition and behavior reduction goals should be listed as well. For initial requests, please document baseline. For subsequent requests, please document new baseline and quantify progress or regression over the previous treatment days.*
All information in the chart must be completed.

BASELINE BEHAVIORS AND DATE	TARGETED BEHAVIOR GOAL AT 6 MONTHS	TARGET GOAL DATE	LONG TERM GOALS	FOR SUBSEQUENT REQUESTS: QUANTIFY PROGRESS TOWARD TARGETED BEHAVIOR GOALS (%)

RECOMMENDED TREATMENT HOURS/SESSIONS

	Direct Patient Support- Hours	**Caregiver/Parent Training- 1 session per day**
Recommended Hours and Setting (indicate # of Sessions for Patient/Caregiver/Parent Training that reflect number of units requested on the Prior Authorization)		
CPT codes requested: **Effective units requested to cover 6 months from effective date:** **Effective date requested:**		

TREATMENT PLAN IMPLEMENTATION

Treatment Plan: This section should include a brief overview of the treatment plan, including:

1. How will ABA be applied to the patient *(e.g., ABA applied to a child will include home and community-based 1-1 intervention for (x) hours per week for target goals)*

2. The parent/caregiver training plan.

3. Coordination of treatment plan with other providers, (*e.g., speech pathology, medical providers, school, outpatient psychologist, teachers, etc.).*

4. Transition plan and anticipated outcome of treatment.