Applied Behavioral Analysis Prior Authorization Form
Massachusetts

Massachusetts Clarity Plan must use this Standard Form

For WellSense MA plans – Fax: 857-264-2673
Provider Portal: HealthTrio connect - Sign In

Today's date: ___________ **Date range of requested sessions:** ________ to _________

For initial request, you may request services for 3-month timeframe.
For continued services, you may request services for 6-month timeframe.

Applied behavioral analysis (ABA) services require one of the following prior authorization approvals:

☐ Request for initial evaluation: Submit pages 1-3 with a copy of the following:
- Individualized education program (IEP) (specific to MassHealth)
- Comprehensive diagnostic evaluation completed by a neurologist, pediatrician, psychiatrist, psychologist, or other licensed physician experienced in autism or Down Syndrome Treatment.

☐ Request for continued services: Submit pages 1-6.

The Board-Certified Behavioral Analyst (BCBA) rendering and/or supervising the services should complete this form. Submission of this form does not guarantee authorization of request.

Member information	
Member name (last name, first name, middle initial)	
Member ID#	Member date of birth(mm/dd/yyyy)
Member address (street, city, state, zip code)	
Phone	
Current ICD-10 diagnosis:	

CLEAR FORM

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Provider information	
Agency name	NPI#
BCBA NPI#	BCBA license #
Name of BCBA professional who will perform/supervise services:	
Provider address (street, city, state, zip code)	
Tax ID#:	Fax#:
How many times have you seen this patient?	Date of most recent contact?
Name and phone # of person to contact with questions and/or authorization decision information:	

Requested services:

ABA codes for Massachusetts Products		
Code	**Description** **1 Unit = 15 minutes, 4 units =1 hour** **Please do NOT request units per week. Instead request units per authorization period**	**# of units requested over 6-month time period**
H0031	Treatment planning by a BCBA (15 minute unit)	
97151	Behavior identification assessment, administered by physician or other qualified healthcare professional (15 minute unit)	
97153	Adaptive behaviors treatment by technician (15 minute unit)	
97154	Group adaptive behavior treatment protocol technician (15 minute unit)	

97155	Adaptive behaviors treatment with protocol administered by physician or other qualified health care professionals (15 minute unit)	
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professionals (15 minute unit)	
97157	Multiple – family group adaptive behavior treatment guidance administered by physician or other qualified healthcare professional (15 minute unit)	

For requests for continued services:
Please list the providers, including yourself, from whom your patient has received ABA services.

Other services provider	Start date	End date (if applicable)

Is your patient receiving any special services at school or in the community: ☐Yes ☐No

If yes, which ones? ______________________________

____

____

ABA treatment should include parent/guardian of development behavioral management skills that support effective generalization of the member in-session training. Describe parent/guardian participation. ______________________________

____

____

Indicate other providers (e.g. occupational, physical, or speech therapist) involved in patient's care and any communication you have had with those providers.

Provider and specialty	Communication
Provider name: Specialty: **Primary care provider**	Date: ________________________ Description of care coordination:
Provider name: Specialty: **Behavioral Health provider**	Date: ________________________ Description of care coordination:
Provider name: Specialty: **School-based services**	Date: ________________________ Description of care coordination:
Provider name: Specialty: **Occupational therapist** Please specify:	Date: ________________________ Description of care coordination:

Current medications

If requesting continuing 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 medications? ☐Yes ☐No If yes, please list the medications below:

Medication	Dosage	Treatment length and patient response	Prescribing provider

Treatment goals: If requesting continued services, please identify behaviors you are working with your patient to change. Please attach additional pages if needed. You may attach treatment plan in lieu of this page as long as it contains all of the below information.

Behavior (identify if it is targeted for increase or reduction)	Date behavior identified	Goal	Current level of functioning	Target completion date

Signature of treating BCBA professional: ______________________ Date: __________