VIVA HEALTH®

Outpatient Behavioral Health (BH) - Applied Behavioral Analysis (ABA)

Pre-Authorization Request Form

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To expedite the processing of your request, please complete all sections of the form.
Please print clearly – incomplete or illegible forms may delay processing

Send Fax Form and Supplemental Documents to: 205-449-7049

- Initial and concurrent requests must by pre-authorized. Services performed without prior authorization will not be approved.
- Requests for continued authorization should be submitted 10 days prior to the end of the current authorization.

Member Demographics	Diagnostic Information
Member's Name:	Primary Diagnosis:
Member's ID #:	Additional Diagnosis:
Date of Birth: Age:	Diagnosed by whom:
Gender: M F	Date of Diagnosis:

Provider Information	
Servicing Facility Name:	NPI #:
Address:	
Phone #: ( )	Fax #: ( )
Servicing Provider Name:	NPI #:
Primary Contact Name:	Phone #:

Clinical Information

The patient's symptoms/mental status/clinical status select all that apply:

□ Self-injurious behavior
□ Destructive behavior
□ Aggressive behavior
□ Elopement
□ Poor communication skills
□ Tantrum behavior
□ Poor Social Skills
□ Poor general development skills (ex. Imitation, identifying objects, sharing skills)
□ Self-stimulatory behavior
□ Verbal outbursts
□ Other _____

Current Medications: _____

Previous or current treatment within the past six months related to this patient's condition:

_____

Assessment and Treatment

Standardized Assessment Tool used: _____

In addition to the information on this form, please attach:

- Full Behavioral Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
    - Describe outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms
- Diagnostic evaluation/report

*Information older than 30 days will not be accepted for continued stay review

Authorization Request: □ Initial □ Continued Stay			
Plan of Care Start Date: Plan of Care End Date:			
*Plan of care is subjected to a 6 month timeframe (180 days/26 weeks)			
Adaptive Behavior Treatment	**Units 15 mins/unit**	**CPT Code**	**# of units requested for 6 months time period**
Behavior Identification Assessment		97151	
Observational Behavioral Follow-Up Assessment		97152	
Exposure Behavioral Follow-Up Assessment		0362T	
Adaptive Behavior Treatment by Protocol		97153	
Group Adaptive Behavior Treatment w/Protocol		97154	
Adaptive Behavior Treatment w/Protocol Modification		97155	
Family Adaptive Behavior Treatment Guidance		97156	
Multiple-Family Group Adaptive Behavior Treatment Guidance		97157	
Adaptive Behavior Treatment Social Skills Group		97158	
Exposure Adaptive Behavior Treatment w/Protocol Modification (first 60 mins)		0373T	

*Please ensure that authorization is requested by units vs hours.

Provider Signature Date

License Information

My signature confirms that any paraprofessional under my supervision has the appropriate education and training.