Applied Behavioral Analysis Authorization

Submit completed form electronically using our preferred method at **Availity.com** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax No.:
Name of requesting:	Phone No.:
Note: Please provide appropriate contact information, including best working phone number for Humana staff to contact you if we need clarification or additional information to complete your request.	

Member information		
Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Parent/guardian name:		Phone:
Member's living arrangements: ☐ At home with guardian ☐ Group home ☐ Foster home		
Authorization No. (if applicable):		

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Diagnosis code(s) and date(s) of service (DOS)			
ICD-10*:	ICD-10:	ICD-10:	ICD-10:
Start date of service:		End date of service:	
Type of request: ☐ Initial request ☐ Concurrent request			

* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.

Humana Healthy Horizons® in Louisiana

Humana Healthy Horizons in Louisiana is a Medicaid Product of Humana Health Benefit Plan of Louisiana, Inc.

Service code(s)			
Code:	Units:	Hours per week:	Frequency:
Code:	Units:	Hours per week:	Frequency:
Code:	Units:	Hours per week:	Frequency:
Code:	Units:	Hours per week:	Frequency:
Code:	Units:	Hours per week:	Frequency:

Required clinical documentation

Please attach the following documents:

- ☐ Functional assessment (Please advise the assessment tool utilized and include baseline data graph.)
- ☐ Behavioral support plan and individualized education program (IEP)

Initial request

Please provide the following:

Describe target behaviors to be addressed with applied behavioral analysis (ABA):

Behavior support plan:

Describe short- and long-term goals in the behavioral services program (SMART), including criteria with targeted percentage reductions:

Provide clinical recommendation for services, outlining rationale for quantity in hours per week/day:

Concurrent review:

Progress summary notes:

Concurrent review:

Attach graph to show progress with goals/criteria and provide any additional explanation here:

Provide clinical recommendation for continuation of services outlining rationale and breakdown of quantity in hours per week/day:

Treatment plan and care coordination (Check all that apply.)

- ☐ Treatment interventions are consistent with ABA techniques.
- ☐ The treatment plan and requested services currently occurring are based upon the functional assessment/reassessment care coordination involving appropriate entities.
- ☐ The licensed psychologist or board-certified behavior analyst (BCBA) is responsible for all aspects of clinical direction, supervision and case management, including evaluation of discharge requirements.

ABA services may not be duplicative of services under an individualized family service plan (IFSP) or an IEP.

The recipient's IFSP or IEP has been reviewed, and the proposed treatment and treatment plan are not duplicative. ☐ Yes ☐ No ☐ N/A

An implementation plan must include the following demographic information: member's name, address, date of birth and Medicaid state identification number; behavioral health intervention services; provider's name; and date the plan was developed and revised.

The plan must include the diagnosis and treatment order from the licensed practitioner of the healing arts including scope, amount and duration of services.

Coverage of ABA services

By signing below, the provider ensures the following: Treatment interventions are consistent with ABA techniques; care coordination involving appropriate entities is occurring; the licensed psychologist or BCBA is responsible for all aspects of clinical direction, supervision and case management; and the treatment plan and requested services are based upon the functional assessment.

Signature:	**Date:**

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits, and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any duplication, dissemination or distribution of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify the sender immediately and destroy all information received.