Humana
Healthy Horizons™ in South Carolina

Healthy Connections

ABA Behavioral Health Authorization Request Form

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

Date of Request:	Authorization Begin Date:	Authorization End Date:
Is this an initial authorization request? ☐ Yes ☐ No	If **no**, Date ABA Treatment Began:	

Member Information

Last Name	First Name	Date of Birth
Phone Number	Humana ID#	Gender ☐ Male ☐ Female
Other Ins. ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer.	Language Spoken

Requesting/Billing Provider Information

Provider Name	TIN	NPI
Street Address	City, State, Zip	Discipline/Specialty
Office Contact	Phone Number	Fax Number

Servicing Provider Information

Facility Name	TIN	NPI
Street Address	City, State, Zip	
Office Contact	Phone Number	Fax Number

Supervising Board Certified Behavior Analyst (BCBA)

BCBA Name	BCBA Certification #	Degree/License

I hereby attest that the provider is certified to provide ABA service as defined by the state's licensing requirements. ☐ **Yes** ☐ **No** ☐ **N/A** per state's licensing requirements

Have services been ordered by a board-certified psychiatrist, psychologist, or pediatrician qualified to provide ABA oversight? ☐ **Yes** Include a copy of the BCBA order with this form ☐ **No**

Requested Services

Code	Description	Unit Interval	Units Requested
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional.	15 min.	
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional.	15 min.	
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present)	15 min.	
Other			

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

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Diagnostic and Treatment Information			
Primary Diagnosis		Secondary Diagnosis	
Diagnosis Date		Medical/ Co-occurring Diagnosis(es)	
Date of Most Recent Assessment		Standardized Tool Used for Diagnosis	
Diagnosing Provider		Current IQ Level	

Is the member in school?	☐ **Yes** ☐ **No**	If **yes**, is there an IEP or 504 Plan?	☐ **Yes -** Include a copy with this form ☐ **No**

Psychosocial Barrier(s), if applicable		Psychosocial Barrier(s), if applicable	

Prior Treatment Relative to Diagnosis:

Describe other services received in addition to ABA, including but not limited to PT, OT, ST or mental health services:

Summary of function capacities and areas of impairment:

What type of treatment components will be provided?

Current Psychotropic Medications (if applicable)			
Medication Name	Dosage	Frequency	Date Started

Please explain the current treatment modalities and services currently in place:

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Treatment Plan	
Area of Concern 1	Attach Baseline Level Data for Each Area of Concern
Behavior/deficit to decrease:	
Behavior/skill to increase:	
Methods to be used:	
Goals and skills of parent/guardian:	
Objective criteria for obtaining goal:	
Target date for introduction of goal:	
Attainment date of goal:	
Care coordination needs:	
Interventions to develop appropriate skills/behaviors:	
Area of Concern 2	Attach Baseline Level Data for Each Area of Concern
Behavior/deficit to decrease:	
Behavior/skill to increase:	
Methods to be used:	
Goals and skills of parent/guardian:	
Objective criteria for obtaining goal:	
Target date for introduction of goal:	
Attainment date of goal:	
Care coordination needs:	
Interventions to develop appropriate skills/behaviors:	

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Treatment Plan	
Area of Concern 3	Attach Baseline Level Data for Each Area of Concern
Behavior/deficit to decrease:	
Behavior/skill to increase:	
Methods to be used:	
Goals and skills of parent/guardian:	
Objective criteria for obtaining goal:	
Target date for introduction of goal:	
Attainment date of goal:	
Care coordination needs:	
Interventions to develop appropriate skills/behaviors:	
Attach additional pages to identify other areas of concern as necessary	
Is the member	☐ Initiating treatment ☐ Transitioning from home based intensive ABA to a lower level of care ☐ Transitioning form most to least restrictive setting ☐ Transitioning from a home based ABA intervention program to a school based program
Projected transition plan/goals:	
If applicable, please state the plan for prevention or crisis resolution:	
Is there a crisis plan in place?	

Projected criteria for discharge:	Expected discharge date:	Next level of care:

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