Behavioral Health Treatment
Applied Behavioral Analysis
Authorization Request Form

Please submit the completed form with requested documentation via fax to L.A. Care BH ASD Program Department: Fax: **(213) 438-5054**.
If the provider would like to discuss the request, please call **1-888-347-2264** or **213-438-5631.**

MEMBER INFORMATION		
Name:	Date of Birth:	Medi-Cal ID# (CIN):
Mailing Address:		
Caregiver Name:	Primary Phone Number:	Preferred Language:
DSM-V/ICD-10 Code(s)/Description: ☐ 299.00 ☐ F84.0 ☐ Other:		

REQUESTING PROVIDER INFORMATION		
Request date:	Requested Date of Services:	
Referring Organization Name:	Referring Individual Name:	
Organization Address:		
Phone number:	Fax number:	E-mail:

SERVICING PROVIDER INFORMATION (if different from requesting source)		
Date of referral:	Requested Date of Services:	
Referring Organization Name:	Referring Individual Name:	
Organization Address:		
Phone number:	Fax number:	E-mail:

SERVICE TYPE REQUEST	
☐ **Comprehensive Diagnostic Evaluation (CDE)/ 2nd Opinion**	
☐ 90791: Psychological Diagnostic Evaluation	Total Hours:
☐ **Functional Behavioral Assessment (FBA)** — for initial ABA assessment **All 4 criteria must be met for approval:** 1. Is the member under 21 years old: ☐ Yes ☐ No 2. Has a recommendation from a licensed physician, surgeon, or psychologist that evidence-based BHT services are medically necessary with documentation attached: ☐ Yes ☐ No 3. Is medically stable with documentation attached (e.g., licensed physician note indicating general health): ☐ Yes ☐ No 4. Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID): ☐ Does have a need ☐ Does not have a need **Requested services and hours:** up to 12hours total (48 units)	
☐ H0032-HP (*required*): *FBA (BCBA-D, BCBA, Licensed MA/MS)*	Total Hours:
☐ H0032-HC: *FBA (BCaBA, MA/MS)*	Total Hours:
☐ **Continuity of Care (COC)**—continued ABA services **Requested services and hours:**	
☐ H2019-HN, HN, HC, HP: *Direct Services*	Hours/month:
☐ H0031-HP (Required): *Case Supervision (BCBA-D, BCBA, Licensed MA/MS)*	Hours/month:
☐ H0031-HC: *Case Supervision (BCaBA, MA/MS)*	Hours/month:
☐ H0031-HN: *Case Supervision (BA/BS)* (supporting documents: transcript & attestation)	Hours/month:
☐ S5111-HP: *Parent Education Training (BCBA-D, BCBA, Licensed MA/MS)*	Hours/month:
☐ S5111-HC: *Parent Education Training (BCaBA, MA/MS)*	Hours/month:
☐ S5111-HN: *Parent Education Training* (BA/BS) (supporting documents: transcript & attestation)	Hours/month:

Clinical indication for request/additional information:		
Provider Name and Credentials:	Provider Signature:	Date:

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule services until authorization is obtained.