HIGHMARK. WESTERN NEW YORK

Outpatient Behavioral Health (BH) – ABA Request Form

Send Fax Form and Supplemental Documents to 1-833-581-1867

Please print clearly – incomplete or illegible forms may delay processing

Member Demographics

Member's Name: _____

Member's ID#: _____

Date of Birth:_____Age: Gender: M F

Authorization #: _____

Diagnostic Information

Primary Diagnosis: _____

Additional Diagnoses: _____

_____

Diagnosed by whom: _____

Date of Diagnosis: _____

Provider Information

Servicing Facility Name:_____NPI #: _____

Par or Non-Par: _____

Address:_____

Phone #s: (_____)_____Fax#: _ (_____) _____

Servicing Provider Name:_____NPI #: _____

Primary Contact Name:_____Phone #: _____

Clinical Information

The patient's symptoms/mental status/clinical status selects 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 desired 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

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Authorization Request: ☐ Initial ☐ Continued Stay Start Date of Plan of Care: _____

***Plan of care is subjected to a 6-month timeframe unless otherwise noted below**

Place of Service - School is not an approved/eligible POS for Federal Employee Program (FEP) policies

Adaptive Behavior Treatment	Units 15 mins/unit	CPT Code	Timeframe (180 days/ 26 weeks)	Place of Service (POS)
Behavior Identification Assessment		97151		
Observational Behavioral Follow-Up Assessment		97152		
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 Behavioral Follow-Up Assessment		0362T		
Exposure Adaptive Behavior Treatment w/Protocol Modification (first 60 mins)		0373T		

_____ _____

Provider Signature Date

_____

License Information

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