**ABA Request for Initial Authorization**

Please fax the completed form and diagnostic assessment to the **plan-specific number**, Attention: ABA support team.

*For plan-specific numbers,* ***sign in*** *to* [*MagellanProvider.com*](https://www.magellanprovider.com/news-publications/state-plan-eap-specific-information/autism.aspx)*. From the Resources section, select State & Plan Information, then choose Autism-Specific Information.*

**MEMBER INFORMATION:**

Member name:

Member’s date of birth:

ID#:

Member’s phone number:

Name of parent(s)/guardian(s):

Language/cultural issues:

**AGENCY/PROVIDER INFORMATION:**

Agency name:

Phone number:

Mailing address:

Fax:

MIS/TIN #:

Agency contact name and phone number/email:

Case manager contact:

Supervisor name and phone number for clinical questions:

Provider is in network or out of network:

**MEDICAL INFORMATION:**

PCP name:

PCP phone number:

Mailing address:

Fax:

Email:

Psychiatrist name:

Psychiatrist phone number:

Mailing address:

Fax:

Email:

*Note: Provider and Magellan must have an AUD on file to speak with PCP and/or psychiatrist. Please see the* [*sample AUD*](https://www.magellanprovider.com/media/11814/pcpaud.pdf) *for more information.*

**REQUESTED SERVICES (Note: this form is for FBA only. All requests for ongoing care must be submitted using an updated treatment plan via fax):**

Location:

CPT codes:

Number of hours:

**START DATE OF SERVICES/AUTHORIZATION REQUEST:**

**REASON FOR REFERRAL:**

Identify the severe challenging behaviors that present a health or safety risk to self or others *or* significantly interfere with home or community activities.

[ ]  Health risk

[ ]  Self-injury

[ ]  Aggression toward others

[ ]  Destruction of property

[ ]  Stereotyped/repetitive behaviors

[ ]  Elopement

[ ]  Severe disruptive behavior

**ASSESSMENT TOOL USED FOR DIAGNOSIS AND FINDINGS:**

**CURRENT DIAGNOSIS:**

**SPECIFY ASD DIAGNOSTIC CRITERION MET PER DSM-5:**

**DATE ASD DIAGNOSIS ESTABLISHED AND BY WHOM (Note: attaching documentation is mandatory):**

* Documentation must be within the last 24 months by a MD, PhD in psychology or PsyD.
* Diagnosis must meet DSM-5 criterion to diagnose ASD.
* Validated assessment tools must be included.

**DEVELOPMENTAL EVALUATION COMPLETED?:**  Yes [ ]  No [ ]

**OT EVALUATION COMPLETED?:**  Yes [ ]  No [ ]

**SPEECH AND LANGUAGE EVALUATION COMPLETED?:**  Yes [ ]  No [ ]

**OTHER EVALUATION & DIAGNOSIS TESTS TO RULE OUT OTHER CONDITIONS COMPLETED?:**

**LIST MEDICATIONS (Include frequency and dosage):**

Is the member medication adherent?

**MEDICAL ISSUES:**

OTHER PHYSICAL FACTORS:

Date and results of last physical exam:

Date and results of last dental exam:

Date and results of last hearing exam:

Date and results of last vision exam:

**SPECIAL SUPPORT SERVICES (Provided by the school district, regional center or early childhood program):** Please describe. If there is a current IEP please include a copy.