**Texas Medicaid ABA Request for Initial Authorization**

Please fax the completed form and diagnostic assessment to 1-888-656-0266, Attention: ABA support team.

**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 /LBA overseeing the case:

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 (use 97151 for initial evaluation, up to 6 hours):

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 3 years by a MD, neurologist, PhD, PsyD or licensed psychologist.
* Diagnosis must meet DSM-5 criterion to diagnose ASD.
* Validated assessment tools must be included i.e., ADOS, CARS.

**REFERRAL FOR ABA? (Note: this is required to initiate services):** Yes [ ]  No [ ]

Prescribing provider’s name:

Prescribing provider’s NPI:

Phone number:

Mailing address:

Fax:

Email:

**ESSENTIAL INFORMATION:**

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

**CURRENT DIAGNOSIS AND DATE OF INITIAL DIAGNOSIS:**

**SPECIFY ASD DIAGNOSTIC CRITERION MET PER DSM-5 AND SEVERITY LEVEL**:

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

**OCCUPATIONAL THERAPY (OT) EVALUATION COMPLETED:** Yes [ ]  No [ ]

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

**OTHER EVALUATIVE AND DIAGNOSTIC TESTS COMPLETED TO RULE OUT OTHER CONDITIONS (Hearing and visual assessment, if applicable):**

**TRAUMA HISTORY:**

**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.