This form is to be completed and submitted by **Board Certified Applied Behavioral Analysis (ABA)** providers to request an initial authorization or re-authorization for ABA Treatment Services

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| **Insurance Eligibility Information*****\*Section Required\**** |
| Medicaid ID:       |
| Member’s Health Share Behavioral Health Plan *(please select one)*:  |
| [ ]   | Multnomah County Behavioral Health Plan |
| [ ]   | Clackamas County Behavioral Health Plan |
| [ ]   | Washington County Behavioral Health Plan |
| *To verify member eligibility, please look in CIM or contact Health Share Customer Service at* *503‐416‐8090 or 1‐866‐519‐3845* |
| **Other Primary Insurance Information** *(if applicable)* |
| Check Type of Members Primary Insurance and Complete Plan Information:  |
| [ ]   | Medicare Primary / Medicaid Secondary (Co-Pay Only) |
| [ ]   | Third Party Insurance |
| Carrier:       |
| Group/Policy Number:       |
| Effective Date:       |
| [ ]  | Not Applicable, member does not have other primary insurance |

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| **Member Information*****\*Section Required\**** |
| First Name:       | MI:       | Last Name:       |
| Date of Birth:       | Gender:       |
| Race/Ethnicity *(optional)*:       |  |
| Member Preferred Language:       |
| Interpretation Service Used: [ ]  IRCO [ ]  Passport to Languages [ ]  Linguava [ ]  Telelanguage [ ]  N/A – No Interpretation Services Needed |
| Street Address:       |
| City:       | State:       | Zip:       |

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| **Member Information*****Continued*** |
| Name of Legal Guardian:       | Relationship:       |
| Legal Guardian Preferred Language:       |  |
| Legal Guardian Contact Phone:       |  |
| Legal Guardian Email Address: |  |
| Name of Caregiver:       | Same As Legal Guardian [ ]  |
| Caregiver Preferred Language:       |
| Caregiver Contact Phone:       |
| Caregiver Email Address:       |

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| **Requesting Provider Information*****\*Section Required\**** |
| Referring Provider:       | Agency/Role:       |
| Phone:       | Fax:       |
| Email:       |

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| **Contact Person***(if different than Referring Provider)* |
| Contact:       | Agency/Role:       |
| Phone:       | Fax:       |
| Email:       |

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| **Care Coordination Information*****\*Section Required\**** |
| **Primary Care Provider** |
| Name:       |
| Contact Info:       |
| **Mental Health Provider** |
| Name:       |
| Contact Info:       |
| **Dental Provider** |
| Name:       |
| Contact Info:       |
| **Developmental Disabilities Provider** |
| Name:       |
| Contact Info:       |
| **Medication Management Provider** |
| Name:       |
| Contact Info:       |
| List all current medications and current doses:      |
| [ ]  N/A – Member does not have a Medication Management Provider |
| **DHS Child Welfare Worker** |
| Name:       | Contact Info:       |
| [ ]  N/A – Member does not have a DHS Child Welfare Worker |

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| **Care Coordination Information*****Continued*** |
| **Substance Use Disorder Provider** |
| Name:       | Contact Info:       |
| [ ]  N/A – Member does not have a Substance Use Disorder Provider |
| **School/Early Intervention** |
| Name:       | Contact Info:       |
| School District:       |
| Current Education Plan:  | [ ]  IEP | [ ]  504 Plan | [ ]  ISFP |
| **Other Services/Therapies** |
| Check all that apply:  | [ ]  PT | [ ]  SLP | [ ]  OT | [ ]  Audiologist | [ ]  Optometrist |
| [ ]  Other:        | [ ]  N/A – Member does not receive other services |
| Name of Provider:       | Type of Provider:       |
| Contact Info:       |  |
| Name of Provider:       | Type of Provider:       |
| Contact Info:       |

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| **Requested Services*****\*Section Required\**** |
| Date of Initial ABA Assessment:       | Date of Updated Documentation:       |
| Authorization Date Range:       |
| Requested Hours per Week:       |
| Amount Requested per 6 Months\*: $      |
| ***\*Requested Amount not guaranteed.*** |

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| **Clinical Documentation Checklist*****\*Section Required\**** |
| **Initial Request** |
| Please include **all** of the following information for a complete request:  |
|[ ]  Completed ABA Referral Form B: Request for Treatment |
|[ ]  Current ABA Assessment |
|[ ]  Proposed ABA Treatment Plan that includes D/C criteria |
| **Continuation of Services Request** |
| Please include **all** of the following information for a complete request:  |
|[ ]  Completed ABA Referral Form B: Request for Treatment |
|[ ]  Documentation and tracking of progress and updated standardized assessment tools used to assess progress |
|[ ]  Updated ABA Treatment Plan that includes D/C criteria |

Upon completion of this form, please submit, with **appropriate clinical documentation**, to the member’s assigned Behavioral Health Plan Partner, Attn: Youth Intensive Care Coordination (ICC):

* Clackamas County Behavioral Health**:** Phone: 503-742-5937 | Fax: 503-742-5304
* Multnomah County Behavioral Health**:** Phone: 503-988-4161 | Fax: 503-988-3328 |

Email: aba.carecoordination@multco.us

* Washington County Behavioral Health**:** Phone: 503-291-1155 | Fax: 503-846-4560

 Email: ABA@co.washington.or.us

Requests will be reviewed by the Behavioral Health Plan Partner and a determination will be made within **14 calendar days** of a completed request being submitted.

The referent will be notified of approved authorization or a denial of services. If the authorization is approved, a referral to a contracted ABA provider will be provided by the Behavioral Health Plan Partner.