



BHT/ABA Prior Authorization Form

Member Information

Date of Request: _____

Request Type: Initial Reauthorization

Member Name: _____

DOB: _____

Member ID#: _____

Member Phone: _____

Service Is: Routine/non urgent Urgent*

*** Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent.**

Provider Information

BHT/ABA Provider: Organization Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Provider Contact Name: _____

Phone # _____

Requesting BCBA's Name: _____

Phone # _____

Fax # _____

Provider Status: Contracted with Molina Not Contracted with Molina

Service Type Requested

**Please submit all clinical notes/evaluations/treatment plans along with this authorization request.
For reauthorization requests, please submit a continued treatment plan one (1) month prior to end of authorization.**

- | | | |
|--|---|---|
| <input type="checkbox"/> Comprehensive Diagnostic Evaluation | <input type="checkbox"/> BHT/ABA Functional Behavior Assessment | <input type="checkbox"/> BHT/ABA treatment initiation |
| | | <input type="checkbox"/> BHT/ABA treatment continuation |

Procedure Code	Provider type (Modifier)	Number of Units
Total number of units requested for auth period:		

Dates of Service Requested From: _____ to: _____

Primary Diagnosis Code for Treatment (Including Provisional Diagnosis)	
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