JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive
Hanover, MD 21076

# ABA Prior Authorization Request Form

FOR PROVIDER USE ONLY

Authorization requests will not be backdated and will be started on the date the previous authorization ends or the date received. Please be as accurate as possible with your estimates of units needed. Enter ABA authorization requests on this form. Only the codes covered below can be covered by this request.

EHP Fax: 410-424-4891 USFHP Fax: 410-424-4830

| Provider Group/Facility: | Date of Request: |
|---|---|
| Member Name: | Member ID #: |
| Date Span Requested From: | Date Span Requested To: |

**Instructions:** Enter the number of units (Not the number of hours) expected to be needed per month under Quantity Requested*. Enter the total number of units of each service code requested in Total Requested. Please submit all claims with appropriate Modifiers HO, HN, HM.

| Service Code | Code Time | Code Allowable Frequency | Quantity Requested | Frequency | Total Units Requested |
|---|---|---|---|---|---|
| 97151 | 15 minutes | 16 units = 4hrs in a Six Month Period | | Six Months | |
| 97153 | 15 minutes | N/A | | | |
| 97155 | 15 minutes | N/A | | | |
| 97156 | 15 minutes | N/A | | | |
| T1023* | 15 minutes | 1 unit per Six Months* | | Six Months | |

*Reimbursement is limited to one unit per outcome measure (PDDBI) one unit every six months or Vineland-3/SRS-2: one unit each per two year period Per Tricare. This code is usable by USFHP only.

Please Ensure All Assessments Listed Below are Attached – **USFHP Only (Not required for EHP)**

Printed Name of Treating Clinician with Credentials_____
Signature of Treating Clinician with Credentials_____ Date: _____
Date of Vineland-3 _____ (Please attach Vineland)
Date of SRS-2 _____ (Please attach SRS-2)
Date of PDDBI_____ (Please attach PDDBI)