Johns Hopkins Health Plans

ABA Prior Authorization Request Form

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

Provider Group/Facility: _____ Date of Request _____

Member Name: _____ Member ID Number_____

Date Span Requested FROM_____TO_____

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

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 Codes	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)