ABA Preauthorization Form

INSTRUCTIONS: Complete the form below, and submit via email (see specific email addresses at the end of this form) with relevant clinical notes and medical necessity information. Once Select Health receives this form, we have the following decision time frames to make a benefit determination (unless an expedited review is requested):

- For Commercial Plans: 14 days (Utah), 2 business days (Idaho), 10 days (Nevada), 5 business days (Colorado)
- For Medicare: 14 days (All States)

This request is (check one): **Initial request** **Concurrent request**

- For initial requests submit the diagnostic evaluation report
- For concurrent request submit the updated individualized treatment plan with progress from previous authorization and/or assessment.

This request is (check one): **NON-URGENT** **URGENT**

IF you checked *URGENT*, please provide the phone number of a person who can immediately discuss the case (not general office number or answering service) AND include a written explanation from a medical provider detailing how/why the usual time frames (see above) would:

- Jeopardize the life or health of the member; and/or
- Threaten the member's ability to regain maximum function; and/or
- Subject the member to severe pain and inadequate management of the member's medical condition.
- Note: Scheduling issues DO NOT meet criteria for URGENT.

Immediate Contact Phone Number (complete ONLY if expedited request)

Written explanation for urgent status:

Date: Dates of Service: to

Contact Name: Email:

Phone: Fax:

Patient Information

Patient Name: Date of Birth (mm/dd/yyyy):

City: State:

Primary Health Insurance: ID#: Plan:

Other Health Insurance: ID#: Plan:

Provider Information

Requesting Provider: NPI: Phone Number:

Requesting Provider Address:

Service Provider: NPI: Phone Number:

Servicing Provider Address:

Service Facility: Inpatient Outpatient Office Home Other

If other, specify:

Servicing Facility Address:

Phone Number: Servicing Facility NPI:

Requested Procedures and/or Services

Diagnosis Code	CPT / HCPCS Code	Number of Units	Description

Add separate form if additional codes are required for authorization.

Member ABA Schedule				Member School & Other Therapy Schedule	
Day	**Time Span (hh:mm)**	**Location**	**Lunch/Breaks**	**Day**	**Time Span (hh:mm)**
Monday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Monday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Tuesday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Tuesday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Wednesday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Wednesday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Thursday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Thursday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Friday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Friday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Saturday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Saturday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
Sunday	Time _____ to _____	☐ Office ☐ Home ☐ Other*		Sunday	Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____
	Time _____ to _____				Time _____ to _____

Supports Outside ABA Treatment

Member accessing other school program? ☐ **Public** ☐ **Private** ☐ **Home** ☐ **Other (specify)** _____

Member has IEP, ISP, 504, or ARD in place? ☐ **Yes** ☐ **No - If no, why not (indicate below)?**

_____

Is the member accessing other therapeutic services? ☐ **Physical** ☐ **Occupational** ☐ **Speech** ☐ **NA**

Is there coordination of care with other medical or BH providers? ☐ **Yes** ☐ **No, those are** _____

Submit completed form with relevant clinical notes and medical necessity information via email as follows:

- For Commercial Plans (Large/Small Employer, Self-Funded, Ind.): **commercialUMintake@imail.org - Fax: 801-442-0825**
- For Select Health Community Care® (Medicaid/CHIP): **medicaidUMintake@imail.org - Fax: 801-442-0625**
- For Select Health Medicare: **medicareUMintake@imail.org - Fax: 801-442-0302**

Documentation Submission
If you need more codes authorized, please attach a separate form.

Reduce turnaround time for preauthorization requests by using CareAffiliate®. Some requests even qualify for auto-approval.

To learn more, email **careaffiliate@selecthealth.org** or visit **selecthealth.org/providers/preauthorization/careaffiliate**.

