

Applied Behavior Analysis (ABA) Prior Authorization Form



In the hope to save you, our provider, some time on the phone, we invite you to fill out this form for ABA treatment requests. In filling out this form, you are doing so in lieu of the telephonic clinical review. This form should be completed by a provider who has a thorough knowledge of the Cigna customer's current clinical presentation and treatment history. *Please note: The information contained in this form may be released to the customer or the customer's representative.*

This form is based on our coverage policy for Intensive Behavioral Interventions and can be found:

https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/medical_a-z.html

TIPS FOR COMPLETING THIS FORM:

- Our regular business hours are Monday – Friday, from 7:30am – 5:00pm Central Time
- To help expedite this request, please complete sections as **specifically** and as **clearly** as possible. Omissions, generalities, and illegibility may result in this request being returned for additional information or clarification.
- Typed responses are preferred. If completing by hand, please use blue or black ink and print legibly.
- If treatment plan is referenced for response, please indicate page number.
- Please note ABA assessment codes (97151, 97152, 0362T) no longer require preauthorization unless requesting a network exception. If you are requesting a Network Exception, please fill out our Network Exception request for initial ABA Assessment.
- Please ensure to always submit the most updated forms, which are accessible by visiting the Cigna for Health Care Professionals website (CignaforHCP.com) > Resources > Forms Center > Behavioral Health Forms.

Please save this form to your computer, complete & save the form using Adobe Acrobat Reader DC, then email it to:

ABA@Cigna.com* (preferred) or fax 1.860.687.9230

* Please note that Cigna assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Cigna.

All fields are required.

Customer Information		
Customer Name:	Member ID:	Date of Birth MM DD YYYY / /
Address:		
Customer/Caregiver Contact Information:		
Is the customer diagnosed with Autism Spectrum Disorder (ASD): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of most current diagnostic evaluation and evaluator's name/credentials:		
Please list any additional diagnosis (please include diagnosis and diagnostic code).		

Provider Information		
Supervising Provider's Name:	Tax ID:	
Email Address:	Phone Number: ()	Is Voicemail confidential? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the provider above providing all supervision for the customer's ABA case? <input type="checkbox"/> Yes <input type="checkbox"/> No - If No, please list who else is providing supervision and their credentials.		

Please check what applies. The supervising provider is credentialed or licensed as:

- ☐ BCBA ☐ BCBA-D ☐ LBA ☐ Licensed Psychologist
☐ Other Licensed (Please specify) _____

Clinic Name:

Clinic Contact (if different from provider):

Clinic/Practice Address:

Please indicate level of benefit requested:

- ☐ I am an in-network provider with Cigna and requesting an in-network authorization
☐ I am an out of network provider with Cigna and requesting an out of network authorization
☐ I am an out of network provider and I am requesting an in-network exception. If yes, please answer A and B:
A.) How many assessment units are you requesting during the auth period:
97151: _____ units | 97152: _____ units | 0362T: _____ units
B.) What specialized experience, training or certification in a particular clinical area or patient population do you possess that would support the need for an in network exception request?

Please indicate if authorization is requested to the supervising provider or clinic:

Please list the best times our team could contact you within the next five business days for questions, concerns, or determination information:

Treatment History and Coordination of Care

ABA

How long has the customer been receiving ABA treatment from your agency:

Has there been any gaps in care or changes in supervising provider since last request? ☐ Yes ☐ No
If Yes, please provide information below:

Other Treatment

Is the customer receiving any additional services?

☐ Yes ☐ No If Yes, (check all that apply)

- ☐ Speech Therapy ☐ Mental Health Services ☐ Primary Care (Pediatrician)
☐ Occupational Therapy ☐ Physical Therapy ☐ Services through the school system
☐ Prescribing Physician (note medications below) ☐ Other: _____

Do you collaborate with all of the providers above? ☐ Yes ☐ No ☐ Plan to collaborate very soon

If no, please explain why:

Standardized Assessment

Please indicate which standardized assessment(s) were administered (or indicate page numbers in the documents submitted):

1. Name of Assessment: _____
a. Current Score: _____ Date: _____
b. Previous Score: _____ Date: _____
c. Baseline Score: _____ Date: _____
2. Name of Assessment: _____
a. Current Score: _____ Date: _____
b. Previous Score: _____ Date: _____
c. Baseline Score: _____ Date: _____

If additional assessments were used, please include the assessment, dates of administration, and scores

Current ABA Treatment Information

Place(s) of Service (i.e. Home, Clinic, etc.)

Please attach clinical information to show that an individualized treatment plan has been developed. This should include specific targeted behaviors/skills for improvement, along with clearly defined, measurable, and realistic goals for improving those behaviors/skills and addresses the all of the information below.

I have included information to address the following in the attached _____ * pages of clinical information (check all that apply).

- ☐ Treatment goals are directly related to the symptoms of ASD as defined by the current edition of the DSM
- ☐ Baseline, interim and current data are reported for all goals.
- ☐ The treatment plan includes a measurable parent/caregiver (including teachers and other stakeholders as appropriate) goals to train them in the basic behavioral principles of ABA and to continue behavioral interventions in the home and community with data to demonstrate parent progress with those goals.
- ☐ The treatment plan includes a plan to ensure maintenance and generalization of skills.
- ☐ There are clearly defined, measureable, and realistic discharge criteria that are individualized to the customer.

If any boxes are not checked above, please add information as to why:

* Please indicate how many pages you are attaching, not including this form.

Current Requested Treatment

We encourage you to make any requests for services no earlier than 2-4 weeks prior to the requested start date. This will ensure we have the most up to date clinical information.

Start date for current authorization request: _____

BCBA/Supervisor Hours

Code	Hours	Units	Time Frame
97155*	<input type="text"/>	<input type="text"/>	Per month
97156	<input type="text"/>	<input type="text"/>	Per month
97157	<input type="text"/>	<input type="text"/>	Per month
97158	<input type="text"/>	<input type="text"/>	Per month
0373T	<input type="text"/>	<input type="text"/>	Per month

Technician/RBT Hours

Code	Hours	Units	Time Frame
97153	<input type="text"/>	<input type="text"/>	Per month
97154	<input type="text"/>	<input type="text"/>	Per month

*Are any of the 97155 units used for 1 to 1 direct care with the customer? ☐ Yes ☐ No

If Yes, how many units?

If the above is not the same as what was approved at the last authorization review, please indicate the specific change in units/hours and the clinical rationale.

Supervisor's Signature/E-Signature: _____

Date: _____

Please Note: The information on this form and attached clinical is what will be used in making a determination. The hours/units listed above will be considered the official hour/unit request

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