PRIOR AUTHORIZATION for AUTISM SERVICES

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490. ***Please be aware that coverage of autism services may vary depending on the employer group and provider contract.***

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

Primary Care/Ordering **Provider:**	***Primary Care/Ordering*** **Provider NPI #:**	***Primary Care/Ordering*** **Provider TIN #:**

Primary Care/Ordering **Provider Address:**

Primary Care/Ordering **Provider Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Rendering **Applied Behavior Analysis (ABA) Provider:**	**Is rendering/supervising ABA provider a BCBA (Board Certified Behavior Analyst)?** ***Please check.*** ☐ No ☐ Yes

Rendering **ABA Provider NPI #:**	***Rendering*** **ABA Provider TIN #:**	***Rendering*** **ABA Provider Address:**

Rendering **ABA Provider Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	**Requested Date(s) of Service:**	**Place of Service:** ***Please check answer for 1. and 2.***
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth	From: To:	1. ☐ Home ☐ Provider Office ☐ School 2. ☐ In-Person ☐ Telehealth/Virtual

A. Primary Treating Diagnosis/ICD-10 Code:	**B. Secondary Treating Diagnosis/ICD-10 Code:**

C. Autism Spectrum Disorder (ASD) Diagnosed By:	**C.1. Provider Specialty:**	**C.2. Date of Diagnosis:**

D. Service (s) Requested: ***Please list all requested services/codes regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Procedure/Service: _____ CPT code(s): _____ Hours Per Week: _____

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E. QUESTIONS	**YES**	**NO**	**COMMENTS/NOTES**
1. Does the member have a diagnosis of autism spectrum disorder (ASD) that fits the criteria in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition)?	☐	☐	
2. Does the plan of care include applied behavior analysis (ABA) therapy provided by or supervised by a Board-Certified Behavior Analyst (BCBA)?	☐	☐	
3. Does the plan of care include speech therapy? **Speech therapy benefit limits may vary depending on the employer group. Please verify benefits prior to rendering services.*	☐	☐	
4. Does the plan of care include occupational and/or physical therapy evaluation and treatment for motor deficits (difficulty with movement), motor planning (ability to sequence movement), or sensory dysfunction (problem with processing sensory information? **Occupational and physical therapy benefit limits may vary depending on the employer group. Please verify benefits prior to rendering services.*	☐	☐	
5. Is meaningful and measurable improvement expected from the ABA therapy?	☐	☐	
6. For authorization extension of ABA therapy, is the patient progressing towards treatment goals? **May leave blank if this is the initial request for ABA therapy approval.*	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

****Please fax completed form and medical records to 801-366-7449.***