Utilization Management Request for ABA Authorization Form

CareFirst
Family of health care plans

INSTRUCTIONS

Please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested. Incomplete information may delay processing of your request. Request review timelines vary and some may take up to 15 days. Review timelines are based on applicable NCQA, state and federal requirements.

Participating Providers: To check the status of the authorization, visit CareFirst Direct at **carefirst.com**.

For **initial ABA behavioral assessment requests**, please attach documentation of Autism Spectrum Disorder diagnosis or other diagnosis when submitting this form.

For **concurrent ABA treatment plan requests**, (requests for additional 6 months with updated treatment goals) please attach the new treatment plan when submitting this form.

For **changes/increases/adjustments** to an already approved treatment plan, please reference the authorization # and the specific changes requested along with clinical rationale (if needed).

Please fax all requests for Applied Behavior Analysis to **443-753-2330**.

MEMBER INFORMATION

Member Name	Member ID	Date of Birth

REQUESTOR DETAILS

Office Contact	Date	Phone Number
Email		Fax Number

If requesting Out-of-Network services for a BlueChoice member, please submit a letter of medical necessity explaining why services cannot be provided In-Network.

RENDERING PROVIDER

Group/Facility Name (*if applicable*)

Group/Facility NPI #	Group/Facility Tax ID #

Rendering BCBA, NPI # and Tax ID

Address

SERVICE REQUEST DETAILS

Setting (*select all that apply*)

Office Home School Other

Date range requested	ICD 10 Diagnosis
Procedure Code	# of Units
Procedure Code	# of Units
Procedure Code	# of Units
Procedure Code	# of Units
Procedure Code	# of Units

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