Molina Healthcare of California
Medi-Cal Fax Number: (800) 811-4804
Phone Number: (844) 557-8434

BHT/ABA Prior Authorization Form

Member Information

Date of Request: _____

Request Type: ☐Initial ☐Reauthorization

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: _____

Service Is: ☐Routine/non urgent ☐Urgent*

*** Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent.**

Provider Information

BHT/ABA Provider: Organization Name and Address: _____

_____

Provider NPI/Provider Tax ID# (number to be submitted with claim):_____

Provider Contact Name: _____ Phone #_____

Requesting BCBA's Name: _____ Phone #_____

Fax #_____

Provider Status: ☐Contracted with Molina ☐Not Contracted with Molina

Service Type Requested

Please submit all clinical notes/evaluations/treatment plans along with this authorization request.
For reauthorization requests, please submit a continued treatment plan one (1) month prior to end of authorization.

☐Comprehensive Diagnostic Evaluation	☐BHT/ABA Functional Behavior Assessment	☐BHT/ABA treatment initiation ☐BHT/ABA treatment continuation

Procedure Code	Provider type (Modifier)	Number of Units
	Total number of units requested for auth period:	

Dates of Service Requested From:_____ to: _____

Primary Diagnosis Code for Treatment (Including Provisional Diagnosis)	

For Molina Use Only: