Molina Healthcare of Washington

2025 Applied Behavior Analysis (ABA) therapy Medicaid - prior authorization form

Phone Number: (855) 322-4082
Fax Number: (833) 552-0030

Member information

Plan: ☐ Medicaid Date of Request: _____ Original Start Date of Services: _____

Request Type: ☐ Initial ☐ Continuation of Services ☐ Limitation Extension Request

Member Name: _____ **DOB:** _____

Member Phone: _____ **Provider One# or Member Molina ID#:** _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

*A service request designation is defined as Expedited/Urgent when the treatment requested is required to prevent serious deterioration of the member's health, or if not received could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Provider information

Facility/Provider Status: ☐ Contracted ☐ Out of Network (Please include page 3 with Prior Authorization request)

Name of Person/Facility Sending Request: _____

Phone #: _____ **Fax #:** _____

Treating Provider Name: _____ **Phone #:** _____

Fax #: _____ **Address:** _____

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

_____

UM Contact Name of Treating Provider: _____

UM Phone # _____ **UM Fax #:** _____

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Dates of Service Requested (Start and End Dates): _____ _____

Diagnosis code and description _____

_____

CPT code(s)	Total # of units for requested date span
0362T: Functional Analysis (2 or more CBT, must have LBAT on site) *Limitation Extension request required *This service is limited to a 2-hour assessment, 3x per year.	
0373T: 2:1 Direct Therapy (2 or more CBT, must have LBAT on site)	
97151: Assessment/Treatment Plan Development *Limitation Extension request required *This service is limited to 28 units per assessment, 2x per year.	
97153: 1:1 Direct Therapy (CBT)	
97154: 1 CBT with 2 or more clients	
97155: Behavior Treatment Modification: LBAT with client	
97158: Behavior Treatment Modification: LBAT with 2 or more clients	
H2020: Intensive 48 Day Treatment *PA Required after 48 service days for members under 6. *PA Required for members 6 and older, or if member turns 6 after initiating this service.	

- **Please submit the general information for authorization form, ABA level of support form, signed prescription for ABA, COE Diagnostic Evaluation, and behavior change plan along with this authorization request.**
- **For reauthorization requests, please submit a continued treatment plan 3 weeks prior to end of authorization. Data submitted for continuation of services should be within the last 6 months.**

MOLINA HEALTHCARE

Behavioral health out-of-network authorization request

For out-of-network providers seeking prior authorization for services please include the following:

Member Name: _____

Member Molina ID #: _____ DOB: _____

☐ **Continuity of care**	☐ **No participating providers available**
How long have you been working with this member? What is unique to this member's condition or the services you provide that have prompted this request?	What services have been attempted within a 25 mile* radius of their residence? *50-mile radius for Marketplace.

Are you willing to finalize a single case agreement and bill Molina directly for services rendered? If so, provide business office/contracting contact.

Name: _____

Phone #: _____ Fax #: _____

Email: _____

☐ We are willing to accept 100% of Medicaid Allowable rates for any medically necessary approved services and request a letter stating this.

☐ We request to negotiate rate.

Clinical documentation information

If providing these services or requesting services on behalf of a facility or provider, please submit this information. If applicable, provide rationale for utilizing out-of-network provider.*

Please provide the appropriate clinical information with the request for review: Applied Behavior Analysis (ABA) [Medicaid]:

- An ABA Level of Support Requirement Form
- An Assessment and Behavior Change Plan prepared by the board-certified behavior analyst (BCBA)
- A copy of a signed prescription for ABA therapy services from a COE or QHP.
- A copy of the Diagnostic evaluation confirming the member's diagnosis from a COE or QHP.

For continuation of services for Day Support (H2020) please provide the following information:

- **Start date**
- **Level of Support form**
- **An Assessment and Behavior Change Plan**

  Assessments—assessment tools/procedures used during treatment.

  Functional activities for daily living—weekly documentation of programs/goals implemented during the treatment. This can be presented in graphs.

  Speech therapy—weekly documentation or 12 encounters on individualized speech therapy with an SLP. This can be presented through a table providing dates, amount of time spent, and feedback/coordination with ABA staff.

  Parent training—weekly documentation or 12 encounters showing times of parent training. This can be presented through a table providing dates, amount of time spent, topics discussed, and staff leading the training.

  Collaborating/coordinating with other services—this can be presented through a table providing dates, type of service/provider you coordinated with, and a brief statement on rationale for coordination.

  Discharge/transition to other care—3 occurrences of care coordination/discharge planning

  Functional behavior assessment section—if challenging behaviors are excessive and detrimental to progress, please write out your FBA and any strategies utilized to reduce challenging behaviors.

Forms and additional resources can be found at:
hca.wa.gov/billers-providers-partners/programs-and-services/autism-and-applied-behavior-analysis-aba-therapy