



**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: