DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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DSS
Strong Families - South Dakota's Foundation and Our Future

APPLIED BEHAVIOR ANALYSIS THERAPY PRIOR AUTHORIZATION REQUEST FORM

Form must be ***submitted with medical records*** to support services.

Date:	**Select ABA Service Category:**	
RECIPIENT INFORMATION		
Medicaid ID (9 digits):	**Date of Birth:**	**Sex:** ☐ M ☐ F
Last Name:	**First Name:**	
ABA THERAPY PROVIDER INFORMATION		
ABA Therapy Provider Name:		
ABA Provider NPI:	**ABA Provider Taxonomy:**	
ABA Provider Address:		
Point of Contact Name and Title:		
Fax:	**Phone:**	
NOTE: The determination notice will be sent to the listed point of contact.		

APPLIED BEHAVIOR ANALYSIS THERAPY ASSESSMENT
This section must be completed for the ABA Therapy Provider to perform an ABA Assessment for services.
Diagnosing Physician Name:
Diagnosing Physician NPI: **Taxonomy:**
Date of Diagnosis:
Name of Evidence-Based Evaluation Diagnosis Instrument(s): (Attach a copy to this request)
Autism Spectrum Disorder (ASD) Diagnosis:

APPLIED BEHAVIOR ANALYSIS CARE PLAN AND DIRECT SERVICES

This section must be completed for the initial provision of ABA care plan and direct therapy services. This section should be completed for each 6 month re-authorization of services.

Name of Standardized ABA Assessment(s) used by ABA Therapy Provider: (Attach assessment results to this request)

CARE PLAN

Date of Care Plan:

☐ **I certify that an individualized care plan has been completed and attached for the recipient on this form. The care plan contains the following information:**

- Description of target ASD behavior(s) and goal behavior(s);
- Measurable behavior treatment goal(s);
- Method or treatment protocol intended to decrease target ASD behavior(s) and implement goal behavior(s);
- Criteria to be used for objective assessment of progress towards behavior Treatment goals; and
- Frequency of assessment of criteria towards progress of behavior treatment goals.

Anticipated Duration of Services:

Discharge Plan: (if services expected to end in the next 6 months)

DIRECT SERVICES

CPT Code	Service	Unit Measure	Planned Units		
			Week	Month	6 Months
0364T 0365T	Adaptive behavior treatment by protocol.	30 min.			
0366T 0367T	Group adaptive behavior treatment by protocol	30 min.			
0368T 0369T	Adaptive behavior treatment w/ protocol modification	30 min.			
0370T	Family adaptive behavior treatment guidance	Encounter			
0371T	Group family adaptive behavior treatment guidance	Encounter			
0372T	Group adaptive behavior treatment social skills group	Encounter			

RE-AUTHORIZATION OF ABA DIRECT SERVICES

INDICATE RECIPIENT'S PROGRESS TOWARDS BEHAVIOR GOALS:_____%____
Attach evidence of progress during pervious 6 month period if not included in the care plan.

INDICATE ANY PROPOSED TREATMENT INTERVENTIONS OR MODIFICATIONS: If no modifications are being made to the care plan, please include justification for continued care plan services.

OTHER COMMENTS RELATED TO RECIPIENT CARE:

☐ I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required. There is no other equally effective treatment available which is more conservative or substantially less costly (ARSD 67:16:01:06.02). All other treatment to correct this problem has been exhausted.

PROVIDER NAME: _____

PROVIDER SIGNATURE:_____ **DATE:** _____

REMEMBER TO ATTACH ANY SUPPLEMENTAL MATERIALS/ATTACHMENTS TO THIS FORM BEFORE SUBMITTING TO SOUTH DAKOTA MEDICAID.