DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES 700
GOVERNORS DRIVE
PIERRE, SD 57501-2291
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South Dakota Department of Social Services

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 (All are 15-minute units)	Planned Units		
		Week	Month	6 Months
97151	Behavior identification assessment, administered by physician or other qualified health care professional			
97152	Behavior identification-supporting assessment, administered by one technician			
97153	Adaptive behavior treatment by protocol, administered by technician			
97154	Group adaptive behavior treatment by protocol, administered by technician			
97155	Adaptive behavior treatment guidance with protocol modification, administered by physician or other qualified health care professional			
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional			

97157	Multiple-family adaptive behavior treatment guidance, administered by physician or other qualified health care professional			
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional			

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.