



AETNA BETTER HEALTH® OF KENTUCKY

Applied Behavioral Analysis (ABA) Outpatient Treatment Request Form

Fax as a single document to AETNA BETTER HEALTH OF KENTUCKY 1-855-301-1564

Provider name (direct contact, please print)		Provider phone:	Provider fax:
Member name (please print)	Age	Medicaid ID#	Date of birth / /
Provider NPI: (required)		ZIP	TAX ID
Diagnosis ICD-10:	Comorbid Medical ICD-10 diagnosis:	Initial or continued ABA service request? If continued, how long receiving ABA services?	
Treatment setting:		Medications:	
Intensity of services (hours per week):		Compliant?	

Treatment Plan MUST be included with ABA Outpatient Treatment Request Form.

To determine if a service requires prior authorization, please visit: <http://www.aetnamedicaidportal.com/propat/Default.aspx>

CPT/HCPCS codes requested

Code	Units Requested	Modifier
H2019		

Request start date: _____ End date: _____

Please note: Requests MUST be received within (2) business days of the requested start date. The maximum timeframe that may be requested is (3) months.

Functional impairment rating scale (Check the box to indicate current level of impairment in each domain)					
	Current level of impairment				
	None		Moderate		Severe
Affective: Depression, mania, mood instability, inappropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety: Panic, worry, easily startled, flashbacks, nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD symptoms: Hyperactivity, impulsivity, poor insight, poor judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions & Compulsions: Rituals, fear of contamination, excessive need for orderliness, hair pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reality Construction & Thought processes: Delusions, hallucinations, disorganized or racing thoughts, dissociative states, paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive: Cognitive impairments due to brain trauma, dementia and mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social: Difficulty forming positive relationships, isolation, anger/aggression, interpersonal problems at work/school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None		Moderate		Severe
Substance Abuse: Problematic use of drugs or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harm to Self or Other: Suicidal ideation, intentionally self-injurious behavior, suicide planning, danger to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite/Eating: Disturbances in appetite, anorexia/bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep: Disturbances in sleep patterns, excessive sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other medical conditions: Presence of medical conditions which have significant impact on patient functioning and/or quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check if member has been previously hospitalized: **Date: (if known)** _____

The following information MUST be provided in order to make a determination, along with the Treatment Plan.

Clinical Data: (psycho/social/behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co-occurring disorders and medical conditions, etc.)

Progress reducing target behaviors/skill deficits: (or lack of, and plan to address. If initial ABA request note progress, or lack of, with any previous treatment interventions) _____

(It may be helpful to include monthly progress summaries when requesting continued ABA services)

Compliance with treatment and treatment recommendations: (include plan to address noncompliance. If initial request note compliance history with any previous treatment interventions)

Discharge planning: (when is the member expected to transition to a lower level of care? What is impeding this transition?)

Provider Signature: _____

Date: _____