Applied Behavior Analysis (ABA) Services
Additional Units of Service Request

This form notifies the Department of the intent to continue Applied Behavior Analysis (ABA) services beyond the initial or previously authorized 180 calendar days or 1,260 units of service for a member with a qualifying diagnosis and who meets the Functional Impairment and Eligibility Criteria.

The Department is unable to reimburse a provider for services rendered unless this form is completely and accurately filled out and submitted. Reimbursement may not be given retroactively for failure to submit timely, complete and required documentation. Please upload forms/documentation to Qualitrac via the Medicaid Utilization Review Portal Medicaid Portal - Home - Mountain-Pacific Quality Health (mpqhf.org).

Date of Submission _____

Member Name _____

Date of Birth _____

Medicaid Card ID _____

Parent or Guardian/Caregiver Name _____

Parent or Guardian/Caregiver Contact Information _____

Provider Name _____

Provider Contact Information _____

Provider NPI _____

Provider License Number _____

Start Date for Services _____

By signing below, the service provider confirms in writing all of the following:

☐ A qualified healthcare professional with expertise in the diagnostic area* has performed a Diagnostic Evaluation which has confirmed the qualifying diagnosis and the professional deems the service medically necessary to ameliorate the symptoms of the stated qualifying diagnosis.

*To be eligible for re-authorization of ABA services, the provisional qualifying diagnosis must have been established by one of the following qualified healthcare professionals with expertise in the diagnostic area:

- Child and adolescent psychiatrist
- General psychiatrist with child and adolescent experience
- Psychiatric mental health nurse practitioner with child and adolescent experience
- Developmental pediatrician
- Neuropsychologist/psychologist

☐ The licensed Board Certified Behavior Analyst (BCBA) delivering services has confirmed in writing the continued medical necessity of the service and the expectation that the member's presenting deficits will continue to improve to a clinically meaningful extent.

☐ The parent or guardian/caregiver of the member receiving the services has confirmed in writing a commitment to participate in the goals of the treatment plan.

☐ The licensed BCBA who will be delivering the services agrees to provide all Service Requirements as delineated in the *Montana Medicaid ABA Services Manual* and within nationally accepted standards of practice.

☐ The licensed BCBA who will be delivering the services has agreed to deliver authorized services, not to exceed a maximum of 180 calendar days or 1,260 units of service, whichever elapses first.

☐ The licensed BCBA who will be delivering the services understands and agrees that additional days or units of service beyond those noted above will require prior authorization.

Signature _____ **Date** _____

Required Supplemental Documentation

☐ Diagnostic Evaluation performed by a qualified healthcare professional with expertise in the diagnostic area** which establishes the qualifying diagnosis. Must also include a statement as to the medical necessity of ABA services to ameliorate the symptoms of the qualifying diagnosis.
****Only required for initial Additional Units of Service request.**

☐ Behavior Identification Assessment

☐ Current Treatment Plan

☐ Documentation of Functional Impairment Criteria the member continues to meet.

For Department Use Only

Received Date _____ Staff Initials _____