Applied Behavioral Analysis (ABA) Treatment Request for a Functional Assessment Form



Please print clearly. Incomplete or illegible forms will delay processing. Please return the completed form to AmeriHealth Caritas Louisiana's Behavioral Health (BH) Utilization Management (UM) team at 1-855-301-5356. For assistance, please call 1-855-285-7466.

Member information				
Patient name:		Legal guardian:		
Member date of birth:		Medicaid/health plan #:		
Provider information				
Group/agency name:		☐ In network ☐ Out of network ☐ In credentialing process		
Provider name:		Provider credential: MD PhD LMHP LBA SCABA Tech		
Provider name:		Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech		
Provider name:		Provider credential: ☐ MD ☐ PhD ☐ LMHP ☐ LBA ☐ SCABA ☐ Tech		
Provider name:		Provider credential: MD PhD LMHP LBA SCABA Tech		
Physical address:		Phone number:		Fax number:
Medicaid/provider/NPI #:		Contact name:		
DSM diagnosis:				
Primary Dx:	Secondary Dx:		Medical D	c

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to AmeriHealth Caritas Louisiana BH UM for a medical necessity determination.

1. Comprehensive Diagnostic Evaluation (CDE).

Treatment request:

ABA services	Units	CPT code	Time frame (weekly/monthly)	Limitation reminders
Behavior identification assessment (ABA)		97151		15 minute units



Comments/additional information:						
Provider signature						
My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications						
as applicable.						
Provider signature	Credentials	Date				

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