Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

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 or SKY 1-833-689-1424**

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: **Intensity of services (hours per week):**		**Medications:** **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
97151		
97152		
97153		
97154		
97155		
97156		
97157		
97158		

Request start date:_____ End date:_____

Please note: Requests MUST be received within (2) buisness days of the requested start date. The maximum timeframe that may be requested is (6) months.

Functional impairment rating scale (Check the box to indicate current level of impairment in each domain)

	Current level of impairment				
Affective: Depression, mania, mood instability, inappropriate	None ☐	☐	Moderate ☐	☐	Severe ☐
Anxiety: Panic, worry, easily startled, flashbacks, nightmares	☐	☐	☐	☐	☐
ADHD symptoms: Hyperactivity, impulsivity, poor insight, poor judgment	☐	☐	☐	☐	☐
Obsessions & Compulsions: Rituals, fear of contamination, excessive need for orderliness, hair pulling	☐	☐	☐	☐	☐
Reality Construction & Thought processes: Delusions, hallucinations, disorganized or racing thoughts, dissociative states, paranoia	☐	☐	☐	☐	☐

Cognitive: Cognitive impairments due to brain trauma, dementia and mental retardation	□	□	□	□	□
Social: Difficulty forming positive relationships, isolation, anger/aggression, interpersonal problems at work/school	□	□	□	□	□
	None		Moderate		Severe
Substance Abuse: Problematic use of drugs or alcohol	□	□	□	□	□
Harm to Self or Other: Suicidal ideation, intentionally self-injurious behavior, suicide planning, danger to others	□	□	□	□	□
Appetite/Eating: Disturbances in appetite, anorexia/bulimia	□	□	□	□	□
Sleep: Disturbances in sleep patterns, excessive sleep	□	□	□	□	□
Other medical conditions: Presence of medical conditions which have significant impact on patient functioning and/or quality of life	□	□	□	□	□

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-occuring 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:_____