Outpatient Behavioral Health (BH) – ABA Treatment Request: Required Information for Precertification

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We've made it easy for you to request services and submit any applicable clinical information. Just use our provider portal on Availity. Register today at Availity.com/aetnaproviders. Once your account is ready, you can start submitting requests right away.

- For additional information on Availity, go to: **https://www.aetna.com/health-care-professionals/resource-center/availity.html**

Requesting authorizations on Availity is a simple two-step process
Here's how it works:

1. Submit your initial request on Availity with the Authorization (Precertification) Add transaction.
   - Note: Every precertification request should have a unique reference number
2. Then complete a short questionnaire, if asked, to give us more clinical information.
   - If you receive a pended response, then complete this form and attach it to the case electronically.

About this form: If you are not utilizing availity you must call our precertification department and submit a precertification request prior to submitting this form with your clinical information. This form will help you supply the right information with your precertification request. Failure to submit applicable medical records may result in a delay or denial of coverage.

Don't use this form for Maryland and Massachusetts.

What you need to know
Effective **August 1, 2026,** this form replaces all other Applied Behavior Health Analysis (ABA) precertification information request documents and forms. You can initiate a request electronically. Or you can call our Precertification Department.

A completed fax form contains confidential information.
Only the individual or entity it's addressed to can use it. If you're not the intended recipient, or the employee or agent responsible for delivering the form to the intended recipient, you can't disseminate, distribute or copy the completed form. If you received the completed form in error, call us at **1-800-624-0756 (TTY: 711)** or **1-888-632-3862 (TTY: 711)**.

How to fill out this form
As the patient's attending provider, you must complete all sections of the form. Do not use this form to initiate a precertification request. **To initiate a request, submit electronically on Availity or call our Precertification Department.** Submit your medical records to support the request with your electronic submission. **Don't use this form for Maryland and Massachusetts.**

When you're done
Once you've filled out the form, submit it and all requested medical documentation to our Precertification Department by:

- If your request was submitted via telephone, you either:
  - Access our provider portal via Availity; enter the Reference number provided and attach this form and all requested medical documentation to the case or
  - Send your information to **FaxHub:**
    - **833 596-0339**
    - The fax number above is for clinical information only. Please send specific information that supports your medical necessity review. **Please continue to send all other information to the appropriate fax numbers.**

What happens next?
Once we receive the requested documentation, we'll perform a clinical review. Then we'll make a coverage determination and let you know our decision. Your administrative reference number will be on the electronic precertification response.

How we make coverage determinations
We encourage you to review **Clinical Policy Bulletin #648: Autism Spectrum Disorders, and Applied Behavior Analysis Medical Necessity Guide**, before you complete this form. You can find the policy by visiting the website on the back of the member's ID card. You can also review the **Applied behavior analysis medical necessity guide**.

Questions?
If you have any questions about how to fill out the form or our precertification process, call us at **1-800-424-4047 (TTY: 711)**.

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Section 1 – Provide the following general information

Typed responses are preferred. If the responses cannot be typed, they should be printed clearly.

Member name	Case reference number
Member telephone number	
Member ID	Member date of birth / /
Provider/Provider Group name	Provider/Provider Group TIN or PIN number, and Network status: ☐ Participating ☐ Non-Participating TIN number: PIN number:
Provider/Provider Group full address (Service Location)	Provider/Provider Group phone number
Name, telephone number **and** email address of Contact person for this request	Is Voicemail confidential? ☐ Yes ☐ No
Requested start date of procedure or service / /	How long has the member received ABA services?
Current DSM-V diagnosis code(s):	Diagnosing Provider (name and credentials)

Select the CPT codes which best describe the service(s) that you will provide and enter the hours needed.

Assessment Codes

- ☐ **97151** _____ **Hours** per auth period
- ☐ **97152** _____ **Hours** per auth period
- ☐ **0362T** _____ **Hours** per auth period

Treatment Codes

- ☐ **97153** _____ **Hours** per week
- ☐ **97154** _____ **Hours** per week
- ☐ **97155** _____ **Hours** per week
- ☐ **97156** _____ **Hours** per week
- ☐ **97157** _____ **Hours** per week
- ☐ **97158** _____ **Hours** per week
- ☐ **0373T** _____ **Hours** per week

Are any ABA hours being requested during class? ☐ Yes ☐ No

If so, how many and for which codes?

If the above requested hours are not the same as what was approved at the last review, please indicate the specific clinical rationale for the change:

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Section 2 – Provide the following member-specific information

1. Who is supervising/directing the ABA services? (name, credential/certification, and phone number)

Is Voicemail confidential?
☐ Yes ☐ No

2. Is the member receiving any additional services? ☐ Yes ☐ No If Yes, (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Mental Health Services ☐ Primary Care Physician ☐ Services through the school system
☐ Prescribing Physician - If so, Medications: _____
☐ Other: _____

Do you collaborate with all the providers above? ☐ Yes ☐ No
If no, please explain why:

3. Check boxes to ensure the following essential elements of quality care are met:

☐ Diagnosis of Autism Spectrum Disorder
☐ Identifiable target behaviors that impact functioning Involvement/Coordination with supplemental resources
☐ Primary caregiver(s) participate in treatment
☐ Time-limited, individualized, measurable treatment plan
☐ Service providers are appropriately licensed/certified

4. The member displays impairment in the following areas (attach supporting data that demonstrates current severity level of each impairment) select all that apply:

☐ Self-injurious behavior
☐ Destructive behavior
☐ Aggressive behavior
☐ Restrictive/Repetitive behaviors
☐ Expressive/Receptive language
☐ Social/Emotional reciprocity
☐ Ability to seek/develop shared social activities
☐ Ability to recognize danger/risks
☐ Ability to advocate for self
☐ Self-Care skills impeded by symptoms of Autism

5. Please include the following supporting documentation with your request, where applicable

- Results of a standardized assessment (i.e. Vineland, ABAS, VB-MAPP) completed within the past 12 months. Re-evaluation of interventions and progress has been performed (every 6 months) to assess the need for ongoing ABA; **AND** a repeat validated assessment has been done every 6-12 months to demonstrate response to intervention. Include the member's IQ, if available
- A time-limited, individualized treatment plan that has clearly defined and measured target behaviors, including baseline levels and quantifiable criteria for progress. The plan describes behavioral intervention techniques appropriate to the target behaviors, reinforcers selected, and strategies for generalization of learned skills are specified. Include baseline, interim and current data for all goals. Include the results of a functional behavior assessment and/or skills assessment, as applicable
- Supporting data that demonstrates the level/severity of impairment justifies the number of hours requested
- Primary caregiver(s) have measurable goals that work to reinforce interventions and generalize gains
- Clearly defined, measurable, and realistic criteria for titration of hours and ultimate discharge, including an aftercare plan
- There is involvement of, or referrals to, appropriate health care, community, or supplemental resources.
- Describe any barriers to providing this information and efforts to address those barriers
- Any additional details to be considered for this request

Section 3 – Read this important information

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Section 4 – Sign the form. Just remember: You can't use this form to initiate a new precertification request.

Form completed by	Title