Applied Behavior Analysis (ABA)
PRIOR APPROVAL REQUEST-FEP

FEP fax to: 866-948-8823
(Handwritten faxes not accepted.)

PREMERA BLUE CROSS

Request date: _____

MEMBER/PATIENT: _____ Date of birth: _____	
Member ID: _____ Suffix: _____ Group #: _____	
PROVIDER NAME: _____	Phone: _____ Fax: _____
Agency Name:_____	Contact person: _____
Address: _____	Tax ID (**required**):_____
City: State: ZIP:	NPI # (**required**): _____

CLINICAL INFORMATION needed. ICD diagnosis code_____

Initial Request: Include verification that diagnosis of an autism spectrum disorder was made by an appropriate diagnosing provider.

SERVICE REQUEST: Initial Request or Ongoing Treatment

Code & Description	Units per week	Hours per week	
0362T assessment, professional			
97151 assessment, professional			
			Location of Service
97155 program modification, professional			Home: ☐ Clinic: ☐
97156 family treatment, professional			Home: ☐ Clinic: ☐
97158 group treatment, professional			Home: ☐ Clinic: ☐
			Units per week at each Location of Service
97153 direct treatment, technician			Home: Clinic: *School:
97154 group treatment, technician			Home: Clinic: *School:

***NOTE:** Benefits are **not** available for ABA performed as part of an educational program; or provided in or by a school/educational setting. Please see the member's Blue Cross & Blue Shield Service Benefit Plan, Section 6 – General Exclusions; fepblue.org/plan-brochures

Note: Unless specifically requested elsewhere in this document, do not send a DNA or other genetic sample, or the results of any genetic typing, test, or analysis, including DNA.