

**Applied Behavior Analysis (ABA)
PRIOR APPROVAL REQUEST-FEP**

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



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:
<p>*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</p>			

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.

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