Molina Healthcare of California
Medi-Cal Fax Number: (800) 811-4804

BHT/ABA ASD Prior Authorization Form

Member Information

Date of Request: ____

Request Type: ☐Initial ☐Reauthorization

Member Name: ____ DOB: _____________________________________

Member ID#: ____ Member Phone: _____________________________

Service Is: ☐Routine/non urgent ☐Urgent*

*** Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent.**

Provider Information

BHT/ABA Provider: Organization Name and Address: ____

____

Provider NPI/Provider Tax ID# (number to be submitted with claim):____

Provider Contact Name: _______________________________________ Phone #_____________________________

Requesting BCBA's Name: _______________________________________ Phone #_____________________________

Fax #_________________________________

Provider Status: ☐Contracted with Molina ☐Not Contracted with Molina

Service Type Requested

- **Please submit all clinical notes/evaluations/treatment plans along with this authorization request.**
- **For reauthorization requests, please submit a continued treatment plan one (1) month prior to end of authorization.**

☐Comprehensive Diagnostic Evaluation	☐BHT/ABA Functional Behavior Assessment	☐BHT/ABA treatment initiation ☐BHT/ABA treatment continuation

Procedure Code	Provider type (Modifier)	Number of Units

Dates of Service Requested: ____

Primary Diagnosis Code for Treatment (including Provisional Diagnosis)	

For Molina Use Only: