Request Type:
☐ Assessment
☐ BAI Initial
☐ BAI Modification

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Fee-for-Service Submittal Detail
Forms should be submitted via email:
HFS.ABS@illinois.gov

Prior Authorization for Applied Behavior Support (ABS) Services

1. RECIPIENT / PARENT INFORMATION

Recipient First and Last Name:	Date of Birth:	RIN:		Phone Number:
Address:	City:	State:	Zip Code:	County:

Parent or Guardian Info.

Relationship to Recipient: ☐ Parent ☐ Guardian ☐ Other: ____

First and Last Name:	Phone Number:	County:
Address:	City:	State: / Zip Code:

2. DIAGNOSTIC DETAILS: List all known relevant diagnosis information for the recipient.

Comprehensive Diagnostic Evaluation (CDE):

Date of CDE Completion: ____ Assessment Type: ☐ ADOS ☐ GARS ☐ ADI ☐ CARS

DSM-5 Diagnosis:		ICD- 10 Diagnosis:		Primary
Code	DSM-5 Name	Code	ICD-10 Name	
				☐
				☐
				☐
				☐

3. TREATMENT SERVICES REQUIRING PRIOR AUTHORIZATION

Behavioral Assessment and Treatment Planning (BATP):

☐ I am requesting in excess of 6 hours of BATP services within 180-day period and have attached a narrative detailing the clinical need.

Behavior Analytic Intervention (BAI)

☐ I am requesting the Behavior Analytic Intervention (BAI) services, detailed below, consistent with the recipient's BATP.

Service Code	Service Name	Service Start: ____	Service End: ____
☐ 97153	Adaptive Behavior Treatment by Protocol	Units: ____	
☐ 97155	Adaptive Behavior Treatment w/ Protocol Modification	Units: ____	
☐ 97154	Group Adaptive Behavior Treatment by Protocol	Units: ____	
☐ 97158	Group Adaptive Behavior Treatment w/ Protocol Modification	Units: ____	
☐ 97156	Family Adaptive Behavior Treatment Guidance	Units: ____	
☐ 97157	Multiple-Family Group Adaptive Behavior Treatment Guidance	Units: ____	
☐ 0363T	Adaptive Behavior Treatment w/ Protocol Modification	Units: ____	

BCBA to RBT Ratios:

% of BCBA Time Requested	% of RBT Time Requested
0%	0%

4. RECIPIENT'S TREATMENT TEAM

Primary Care Physician: ____ Date of Most Recent Visit: ____	NPI:	Organization Name:	Contact Name:	Phone: ____ Email: ____
☐ Same as above. Provider Ordering ABS ____	NPI:	Organization Name	Contact Name	Phone: ____ Email: ____
Rendering BCBA Provider: ____	NPI:	Organization Name	Contact Name	Phone: ____ Email: ____

5. ATTESTATION AND SIGNATURE

Staff Completing (print name)	Credentials:	Phone Number:
Signature	Date (mm/dd/yyyy)	
Licensed Provider Name:	NPI:	HFS Provider ID:

Instructions for the Submission of Requests for Prior Authorization for ABS Services

INSTRUCTIONS

Form - Required for all ABS Service Request Submissions.

Section 1 – Recipient/ Parent Information

1. Recipient First and Last Name. Enter the full name, first and last, of the individual seeking the service.
2. Date of Birth. Enter the date of birth of the individual seeking the service.
3. RIN. Enter the State of Illinois recipient identification number (RIN) of the individual seeking the service.
4. Phone Number. The best contact phone number for the recipient/ parent seeking the service.
5. Address. The street address of the residence of the individual seeking the service.
6. City. The city of the residence of the individual seeking the service.
7. State. The state of the residence of the individual seeking the service.
8. Zip Code. The zip code of the residence of the individual seeking the service.
9. County. The county of the residence of the individual seeking the service.
10. Relationship to Recipient. Select the appropriate relationship between the caregiver and recipient.

Section 2 – Diagnostic Details.

1. Date of CDE Completion. Enter the date of completion for the recipient's Comprehensive Diagnostic Evaluation.
2. Assessment Type – Check Box. Identify the type of standardized tool used as part of the recipient's CDE:
   - Autism Diagnostic Observation Schedule (ADOS);
   - Gilliam Autism Rating Scale (GARS);
   - Autism Diagnostic Interview (ADI); or
   - Childhood Autism Rating Scale (CARS).
3. DSM-5 Diagnosis. List all known, relevant DSM diagnoses of the individual seeking service.
4. ICD-10 Diagnosis. List all known, relevant ICD-10 diagnoses of the individual seeking service.
5. Primary Indicator. Please indicate, from the list of diagnoses provided, the primary diagnosis necessitating the services being requested.

Section 3 – Treatment Services Requiring Prior Authorization

1. Behavioral Assessment and Treatment Planning (BATP) – Check Box. Select this box if the individual seeking services requires more than six (6) hours of BATP services in a 180-day period.
2. Behavioral Analytic Intervention (BAI) – Check Box. Select this box if the individual seeking services requires one or more BAI services listed below. Note: A provider seeking Prior Authorization for ABS Services should NOT check both the BATP check box and the BAI check box at the same time.
3. Service Code – Check Box. Check the box of all CPT codes you are seeking prior authorization to deliver to the recipient.
4. Service Start. Enter the prospective date the recipient is seeking to begin service delivery under this approval.
5. Service End. Enter the targeted end date of services for this request, not to exceed 180 days from the Service Start Date.
6. Units. Enter the total number of units per BAI service the recipient is seeking to have approved for the effective period (Service Start Date to Service End Date).

Section 4 – Recipient's Treatment Team

1. Primary Care Physician. Please list the name (first and last) of the individual's Primary Care Physician (PCP).
2. NPI. Please list the National Provider Identification number of the individual's PCP.
3. Organization Name. If the Practitioner works for a medical group, practice group, hospital, or other entity, please provide the name of the entity.
4. Contact Name. Please provide the name (first and last) of the most appropriate person to contact (e.g. receptionist, assistant, nurse) when seeking to talk with named Practitioner.
5. Phone. Please provide the most appropriate phone number to contact the listed Practitioner.
6. Email. Please provide the most appropriate email to contact the listed Practitioner.
7. Date of Most Recent Visit. Enter the date of the recipient's last medical appointment with their Primary Care Provider.
8. Same As Above – Check Box. Check this box if the Ordering Provider is the same as the same individual as the recipient's Primary Care Physician.
9. Ordering Provider/ Specialty. Please list the name (first and last), clinical credentials (e.g. MD, DO, PsyD, etc.), NPI and contact information for the practitioner ordering ABS services. This provider is required to be a physician or psychologist. Ordering provider can be skipped when the "Same as above" check box is marked.
10. Rendering BCBA Provider. Please list the name (first and last), NPI and contact information of the BCBA practitioner responsible for overseeing the completion and delivery (rendering) ABS services requested.

Section 5 – Attestation And Signature

1. Staff Completing. Please list the name (first and last) of the individual completing the form.
2. Credentials. Please list the credentials associated with the individual completing the form, if the individual is a licensed practitioner in the state in which they are employed. If the individual completing the form is not a licensed practitioner, please provide the role that the individual completing the form holds within their organization (e.g. UM Nurse, Records Associate, etc.).
3. Phone Number. Please provide the most appropriate phone number to contact the individual completing the form.
4. Signature. The person completing the form must sign the document in this box.
5. Date. The person completing the form must provide the date that they signed the form.
6. Licensed Provider Name. The name of the entity or practitioner that the person completing the form is representing in the submission of the Prior Authorization request.
7. NPI. The National Provider Identification number for the entity listed in the "Provider Name" box.
8. HFS Provider ID. The provider identification number for the entity listed in the "Provider Name" box, as assigned by HFS at the point of enrollment in the Illinois Medical Assistance program. This number is usually a combination of the provider's 9-digit FEIN and a three digit location code assigned by HFS.

Instructions for the Submission of Requests for Prior Authorization for ABS Services

Attachments – Required upon request, or as detailed below.

1. Physician Referral For Services. Physician order and referral for ABS service delivery.
2. Comprehensive Diagnostic Evaluation (CDE). The recipient's completed CDE must be submitted with the first submission for services and upon request from the reviewer for all subsequent submissions.
3. Documentation of Functional Impairment. If the CDE was completed more than 24 months before the date of request for prior authorization completion, provide a current, individualized documentation of functional impairment and treatment recommendation for ABS Services from MD or LCP.
4. Clinical Narrative. Requests for BATP services in excess of six (6) hours per every 180-day period should be accompanied by a clinical narrative detailing why more than six (6) hours of assessment and treatment planning are needed to complete the recipient's BATP.
5. Behavioral Assessment and Treatment Plan (BATP). Requests for Behavioral Analytic Intervention (BAI) services should be accompanied by the recipient's BATP, completed within 30 days of request date for prior authorization of BAI services.

Submittal of Request

The Request for Prior Authorization for ABS Services must be completed in full.

Upon the completion of the Applied Behavior Support Services Prior Authorization Form and the gathering of all necessary clinical documentation and attachments – the request for services should be submitted to HFS and its review agent via email at:

HFS.ABS@illinois.gov