Connecticut BHP
Supporting Health and Recovery

ASD REGISTRATION / AUTHORIZATION TEMPLATE

Facility/Provider Name:

Name of contact who filled out this form:

Contact # & Ext:

Member Name:

Medicaid/Consumer ID#: **DOB:** **and/or SSN:**

ABA Service	CPT Code	Request Format	Requested Start Date	Requested Units/Hours Per Week	Location of Services (Home, Office, Community, etc.)	Who is Providing the Service? (BCBA, Licensed Clinician, APRN, Technician, etc.)
ABA ASSESSMENT REQUEST						
Behavior Assessment (ABA)	**H0031***	Up to 10 units based on need				
	Provide clinical rationale for Behavior Assessment request including tools you anticipate using:					
Treatment Plan Development (APB)	**H0032**	1 unit				
Program Book Development (APB)	**H0032 TS**	Up to 3 units				
ABA SERVICES REQUEST						
ABA Therapy (ABB) *Direct services by technician*	**97153**	Hours per week				
ABA Therapy (ABB) *Direct services by BCBA or Licensed Clinician*	**H2014**	Hours per week				
Direct Observation and Direction (AOD)	**H0046**	Hours per week (At least 10% of ABB)				
Group Treatment Services (ASG)	**97158**	Days per week & hours per day				
*All levels of care must meet medical necessity						