Amerigroup	Sunflower	United
Fax: 800-505-1193	Fax: 844-824-7705	Fax: 855-268-9392

Autism Authorization Request Form

Please print clearly – incomplete or illegible forms will delay processing.

Date: _____

Member Name: _____ **DOB:** _____

Address: _____ **SSN:** _____

Medicaid ID: _____ **Other Primary Insurance:** _____

Check AGENCY or PROVIDER to indicate how to authorize services

Agency/Group Name: _____ **Contact Name and #:** _____

NPI & TIN #: _____ **Fax #:** _____

Provider Name: _____ **Phone #:** _____

Address: _____ **City/State:** _____

Autism Services	Dates of services requested (start-end)	Total units requested	Total units used
Consultative Clinical and Therapeutic Services (CCTS)	-	____	____
Assessment	-	____	____
0359T –Initial Behavioral Identification Assessment–Per session code	-	____	____
0360T-Observational Behavioral Follow-up Assessment–First 30 min	-	____	____
0361T-Observation Behavioral Follow-up Assessment–Each additional 30 min	-	____	____
Treatment	-	____	____
0368T - Adaptive Behavioral Treatment- First 30 min.	-	____	____
0369T - Adaptive Behavioral Treatment- Each additional 30 min.	-	____	____
0370T - Family Adaptive Behavioral Treatment 30 min (limit 2 per day)	-	____	____
Intensive Individual Supports (IIS)	-	____	____
0364T Adaptive Behavioral Treatment by Protocol - First 30 min.	-	____	____
0365T - Adaptive Behavioral Treatment by Protocol - Each additional 30 min.	-	____	____

***Initial annual service limits are 50 hours for CCTS and 25 hours per week for IIS.**

***For initial requests, include documentation of autism diagnosis, doctor recommendation of services, and criterion-referenced standardization assessment.**

***For requests beyond the yearly preset limits, or every 6 months for concurrent requests, include an updated treatment plan and progress summary.**

Additional Information:

Provider Name (Please Print)	**Provider Signature**	**Date**