

Amerigroup
Fax: 800-505-1193

Sunflower
Fax: 866-694-3649

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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 (CTS)	-	_____	_____
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