Autism Resource Program: 877-563-9347 Fax: 816-237-2372

For administrative questions, please contact autismadmin@lucethealth.com. For clinical questions, please contact your Autism Care Manager or the autism department at 877-563-9347.

ABA Authorization Amended Request Form - Revised Dec. 2024, Last Reviewed Nov. 2025

Please complete all parts as clearly and as specifically as possible. Illegibility may result in a delay in the authorization. Omissions and generalities could result in a peer review or denial due to lack of information.

Member Information	
Member's Name:	Member ID #:
Date of Birth:	Current Authorization # being amended:
Contact Information	
Contact Name:	Contact Phone Number:
Contact Email:	Provider Group Fax:
Provider Group Address:	Provider Group Tax ID:
Type of Request	
☐ BCBA Name Change ☐ Hours/ Codes Change ☐ Location Change	
BCBA Name Change	
Name of the BCBA who **will no longer** oversee treatment:	
Name of the BCBA who **will** oversee treatment:	
BCBA Individual NPI:	BCBA Email:

Date the BCBA provider change will take effect:	Is the BCBA in-network with their local Blue Cross Blue Shield plan? ☐ Yes ☐ No
How many units of 97151 should be transitioned to the new BCBA?	
*If BCBA is modifying treatment plan, please attach updated copy.	

Hours/ Codes Change

Total Hours Requested (Sum of what is currently authorized and additional hours you are requesting, if any):

Code	Total Hours
97151	
97152	
0362T	

Total Hours Requested Per Week (Sum of what is currently authorized and additional hours you are requesting):

Code	Total Hours
97153	
97154	
97155	
97156	
97157	
97158	
0373T	

Rationale for amended request:
☐ I attest any goals added to the treatment plan, as a result of this change, meet medical necessity and will be included for next treatment review.
Location Change
New location(s): ☐ Clinic ☐ Home ☐ School ☐ Telehealth ☐ Community ☐ Other: _____
Rationale for location change:
☐ I attest that I have verified benefit coverage for these proposed places of service.