

State of Vermont ABA Medical Prior Authorization Form

 Urgent Request

 Non-Urgent Request

Instructions: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member's health plan in advance of the proposed services. Please refer to information provided on the health plans' website for submission instructions and contact information.

Patient/Member Information (* Required Field)			
*First Name:		Middle Initial:	*Last Name:
*Health Insurance ID#:	*DOB (MM/DD/YYYY): / /		*Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>
*Address:		Apt.#:	
*City:	*State:	*Zip:	Telephone #:
Referring/Requesting Provider Information		Rendering/Attending Provider Information	
First Name: Last Name:		First Name: Last Name:	
NPI/TIN #: Specialty:		NPI/TIN #: Specialty:	
Group/Practice Name:		Group/Practice Name:	
NPI/TIN #:		NPI/TIN #:	
Address: Suite #:		Address: Suite #:	
City: State: Zip:		City: State: Zip:	
Office Contact/ Person Completing Form:			
Telephone #:		FAX #:	
Required Clinical Information (* Required Field)			
*Date of Request:		Is this request for Out-of-Network services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
*Type of Service Requested			
Inpatient Care: Medical Admit <input type="checkbox"/> Mental Health/Substance Abuse Admit <input type="checkbox"/> OB <input type="checkbox"/> Surgery <input type="checkbox"/> Oral Surgery <input type="checkbox"/>		Outpatient/Office Care: Acupuncture <input type="checkbox"/> Chiropractic <input type="checkbox"/> Infusion/Oncology Drugs <input type="checkbox"/> Mental Health/Substance Abuse <input type="checkbox"/>	
Testing: Diagnostic Imaging <input type="checkbox"/> Diagnostic Medical Test <input type="checkbox"/>		Therapies: Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/>	
		Other: DME <input type="checkbox"/> SNF <input type="checkbox"/> Home Health <input type="checkbox"/> Vision/Glasses <input type="checkbox"/> Other <input type="checkbox"/> - please specify:	
*Date Diagnosed:		*Place of Service: Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> - specify:	
*Proposed Date(s) of Service: From: To:		*Facility Where Service Will be Performed:	
*Proposed Number of Inpatient Treatment Days:		*Proposed Number of Outpatient Treatment Visits:	
*Primary Diagnosis:		*Primary Diagnosis Code:	
*Secondary Diagnosis:		*Secondary Diagnosis Code:	
*Name of Proposed Procedure or Test:		*CPT/HCPCS or Revenue Code:	
*Requested DME:			
*DME CPT/HCPCS Code:		*Requested DME Duration (Date(s) of Service):	
*DME Purchase Price: \$		*DME Monthly Rental Price: \$	

 Additional Clinical Information Attached: (No. of pages)