

Applied Behavioral Analysis Treating Board Certified Behavioral Analyst Change Notification Form

This form is to be used by the existing ABA provider and only when the member's rendering ABA provider or qualified health professional is changing. Please complete all sections of the form. Please submit new BCBA claims after the existing prior authorization has been updated. You will receive a revised prior authorization by letter confirming the change.

Note: This form may not be used to request ABA assessment or treatment services.

Please fax the completed form to 877-361-7656.

		PATIENT A	AND SUBSCRIE	ER INFORMATION	
Patient Full Name:				Patient DOB:	
	Last	First	M.I.	MM/DD/YYYY	
Subscriber Full Name:				Subscriber ID:	
	Last	First	M.I.		
Group Number:					
		CURRENT	RENDERING B	BA INFORMATION	
ABA Authorization ID:				Authorization Dates: to	
					M/DD/YYYY
BCBA Full Name:				NPI:	
	Last	First	M.I.		
Phone:				Email:	
Addragg					
Address:				City, State, Zip Code	
End Date of Treatment v	vith Member:				
End bate of fredericity	vicir iviciriber.	MM/DD/YY	YY		
		NEW RE	NDERING BCB	A INFORMATION	
BCBA Full Name:	 Last	First	M.I.	NPI:	
Linaman Niversland				State of Licensure:	
License Number:				State of Licensure:	
Phone:				Email:	
Address:					
			Number and Street	City, State, Zip Code	
Start Date of Treatment	with Member:		.00/		
		MM/DD/Y	YYY		
I certify that the informa	tion included on	this form is true and	l accurate to the be	st of my knowledge.	
Name of Person Comple	eting Form:			Phone:	
Signatura				Data	
Signature:					