Tennessee ABA Prior Authorization Form

EVERNORTH℠

For Behavioral Providers

To file electronically, providers in Tennessee must register for access to the online prior authorization tool:

To file via facsimile send to:
860.687.9230

To file via email send to:
ABA@Evernorth.com* (preferred)

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

Tennessee mandated policies only

Please only fill out the attached form after confirming that this plan follows Tennessee mandates. If you want to confirm patient's benefits or if you have any questions, please call **1.877.279.7603**. Please note, you can also choose to fill out our Standard ABA Prior Authorization Form located online with our Behavioral Forms.

In the hope to save you, our provider, some time on the phone, we invite you to fill out the attached form for ABA treatment requests. In filling out the form, you are doing so in lieu of the telephonic clinical review. The form should be completed by a provider who has a thorough knowledge of the Evernorth patient's current clinical presentation and his/her treatment history. ***Please note:*** *The information contained in this form may be released to the patient or the patient's representative.* The form is based on our Medical Necessity Criteria for ABA.

TIPS FOR COMPLETING THIS FORM:

- Our regular business hours are Monday – Friday, from 8:30 a.m. – 5:00 p.m. CST
- To help expedite this request, please complete sections as **specifically** and as **clearly** as possible.
- Omissions, generalities, and illegibility may result in this request being returned for additional information or clarification.
- Typed responses are preferred. If completing by hand, please use blue or black ink and print legibly.
- All fields on the form are required.
- The area requesting "Please provide clinical information to show individualized treatment plan has been developed", should include specific targeted behaviors/skills for improvement along with clearly defined, measurable and realistic goals for improving those behaviors/skills and addresses the following:
    - Treatment goals are directly related to the core symptoms of ASD as defined by the DSM-5
    - Baseline, interim and current data are reported for all goals.
    - The treatment plan includes a measurable parent/caregiver (including teachers and other stakeholders as appropriate) goals to train them in the basic behavioral principles of ABA and to continue behavioral interventions in the home and community with data to demonstrate parent progress with those goals.
    - The treatment plan includes a plan to ensure maintenance and generalization of skills.
    - The treatment plan includes clearly defined, measurable, realistic discharge criteria and transition plan across all treatment environments.

*****If space is insufficient or if easier, you are welcome to also attach current treatment plan and/or progress report.

***** Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

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CLEAR FORM

Patient Name:	**Date of Birth:**	**Patient ID #:**
Patient's Home Address:		
Current Diagnosis and evaluator's name/credentials:		Date of Evaluation:
Supervising Provider's Name/Credentials:		Tax ID:
Provider/Clinic Contact Name and Number:		Confidential voicemail: ☐ Yes ☐ No
Clinic Name and Practice Address:		

Please indicate if authorization is requested to Supervisor or clinic:

How long has the patient been receiving ABA treatment with you/your agency? _____

Has there been any gaps in care or changes in supervising providers since last request? ☐ Yes ☐ No

If Yes, Please provide information:

List any additional treatment patient is receiving and how you are coordinating care:

List any current medications:

Benefit Requested: ☐ In-network for in-network provider ☐ Out of Network for out of network provider

☐ In-network for Out of Network provider. If checked, what specialized experience, training or certification in a clinical area or patient population do you possess that would support the need for an in-network exception?

List name of standardized assessment used as well as Current, Previous and Baseline Scores. Please include date for each:

Places(s) of service for Treatment:

Start date for this authorization request:

Please provide clinical information to show individualized treatment plan has been developed (if you are attaching information please list how many pages you attached).

List current requested CPT codes for reassessment and units requested per authorization period:

List current requested CPT codes for Supervision, Parent Training, and Direct treatment. Please indicate units requested per each code per month:

Provider Signature: **Date:**

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