



Medi-Cal

P.O. BOX 11033, ORANGE, CA 92856

Phone: 855-877-3885

Behavioral Health Treatment-Authorization Request Form (BHT-ARF)

(This form is for BHT services only)

Behavioral Health Fax: 714-954-2300

***** IN ORDER TO PROCESS YOUR REQUEST, BHT-ARF MUST BE COMPLETE AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

MEMBER INFORMATION

Member Name (Last, First):			Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:		
Age:	DOB:	Client Index # (CIN):		ICD-10 Dx:	
Mailing Address:				Phone:	

PROVIDER INFORMATION

ABA Provider:			
Provider NPI:		TIN:	Medi-Cal ID:
Address:		Phone:	Fax:
Office Contact:		Provider's Signature:	

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS Code(s). Supporting documentation to include:

- Functional Behavior Assessment Report
- Treatment Plan/Progress Report
- Developmental and Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

REQUESTED PROCEDURES	HCPCS CODE	UNITS AND DURATION (typically 6 months)
Mental health assessment by non-physician	H0031	_____
Mental health service plan development by non-physician (Non-BCBA)	H0032-HN	_____
Mental health service plan development by non-physician (BCBA)	H0032-HO	_____
Skills training and development	H2014	_____
Therapeutic behavioral services	H2019	_____
Home care training to home care client	S5108	_____
Home care training, family	S5110	_____
Other	_____	_____