Behavioral Health Treatment **Phone**: 1-800-549-2022
Behavioral Health Treatment **Fax**: 1-209-762-4760

Health Plan of San Joaquin | Mountain Valley Health Plan

Behavioral Health Treatment Authorization Request Form

☐ Urgent ☐ Routine ☐ Retroactive

Patient Information					
Member Name (Last, First):					
Member ID				Primary Language Spoken	
Date of Birth		Gender:		Require Interpreter	☐ No ☐ Yes
Member Street Address				City, ST, ZIP	
Member Phone				Primary Caregiver	

Requesting Provider			
NPI		TIN	
Name (Last, First)		License Information	
Address		City, ST, ZIP	
Phone		Fax	

☐ **Same as Servicing Provider**

☐ Different Servicing provider, please complete below:

NPI		TIN
Name (Last, First)		License Information
Address		City, ST, ZIP
Phone		Fax

Service(s) Requested

☐ **Functional Behavioral Assessment (FBA) *only*** ☐ **Applied Behavioral Analysis Treatment Program**

Reason for Referral – supporting documentation should include a referral for services by a Licensed Physician or Licensed Clinical Psychologist no less than 2 years from the requesting date.

☐ Tantrum Behavior	☐ Deficits in Safety Awareness	☐ Restrictive, Repetitive Patterns of Behavior
☐ Aggression	☐ Deficits in Self-Help Skills	☐ Other (Please describe)
☐ Self-Injurious Behavior	☐ Skill Acquisition	
☐ Self-Stimulatory Behavior	☐ Property Destruction	
☐ Elopement	☐ Poor Executive Functioning	
☐ Communication Deficits	☐ Deficits in Social Interaction	

ICD 10 Code(s):

HCPC Code(s) and Units requested

HCPCs	☐ H0031	☐ H0032	☐ H0046	☐ H2014	☐ H2019	☐ S5111
Units						
Frequency						

Requested Start Date	

Attach the following documentation:

For FBA only – submit treatment recommendation from Licensed Physician or Licensed Clinical Psychologist

For ABA Treatment Program:

- If new: submit treatment recommendation and from Licensed Physician or Licensed Clinical Psychologist
- If continued service request: submit Progress Report and updated Treatment Plan

NOTE: if treatment recommendation is older than 2 years, a new treatment recommendation must be submitted

Requesting Provider Signature _____ Date _____

Behavioral Health Treatment Service requiring Health Plan approval must be submitted on this form.
Payment is subject to member eligibility and medical necessity determination.
Please confirm eligibility by calling 1-209-942-6320 or IVR 1-209-942-6303.

Fax this form and supporting documents to Health Plan's BHT Department: 1-209-762-4760
If you have any questions, please call the Health Plan's BHT Department: 1-800-549-2022