

## 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 **877-361-7646**. For any questions, call 800-528-7264 or for Federal Employee Program® call 800-528-7264.

### PATIENT AND SUBSCRIBER 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 BCBA INFORMATION

ABA Authorization ID: \_\_\_\_\_ Authorization Dates: \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YYYY MM/DD/YYYY

BCBA Full Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Last First M.I.

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Number and Street City State Zip Code

End Date of Treatment with Member: \_\_\_\_\_  
MM/DD/YYYY

### NEW RENDERING BCBA INFORMATION

BCBA Full Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Last First M.I.

License Number: \_\_\_\_\_ State of Licensure: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
Number and Street City State Zip Code

Start Date of Treatment with Member: \_\_\_\_\_  
MM/DD/YYYY

I certify that the information included on this form is true and accurate to the best of my knowledge.

Name of Person Completing Form: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
MM/DD/YYYY