Fax Completed Form To:
(855) 440-3747

Behavior Analysis Services: Prior Authorization Transition Request Form

GENERAL

Type of Request: ☐ New (prior to initial service)
☐ Continuation of services approved by Beacon
☐ Continuation of services approved by eQHealth
Provide initial eQHealth PA#: _____

RECIPIENT INFORMATION

Recipient #: _____ Age: _____ DOB: _____

Name: _____
(First) (MI) (Last)

PROVIDER INFORMATION

Billing Provider Information

Provider ID: _____
Name: _____
Phone: _____

Referring Provider Information

Provider ID: _____
Name: _____
Phone: _____

REQUESTOR INFORMATION

Requestor Name: _____
Requestor Phone: _____

Preferred Method of contact to receive PA#: ☐ Call Back ☐ Fax

ICD10 DIAGNOSIS

Principal code: _____
Secondary Code(s): _____

SERVICES REQUESTED

HCPS Code	Modifier 1	Modifier 2 (if applicable)	Start Date	End Date	Units
H0031 (Behavior Assessment)	BA				
H0032 (Behavior Reassessment)	BA				
H2012 (Assistant Analyst)	BA				
H2014 (Technician) (For group therapy add "GK" modifier)	BA				
H2019 (Lead Analyst) (For Tel Med add "GT" modifier)	BA				

I hereby attest that, as the provider or provider representative, an order for services has been received for the recipient. In addition, I attest that the treatment plan has been approved by the provider. A provider who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be subject to the application of sanctions, which include, but are not limited to, fines, suspensions, and termination. In addition, the provider may be prosecuted under federal and/or state criminal laws and may be subject to civil monetary penalties and/or fine.

Signature:_____ Date: _____

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eQHealth Solutions certification determination does not guarantee Medicaid payment for services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.