

## 50-1 Treatment Authorization Request Form

This treatment authorization request form should be used for psychological testing, neuropsychological testing, initial requests to start ABA (after a Functional Behavioral Assessment has been completed), and requests to continue ABA services.

This form can be sent via fax or the secure link below.

**Please note that the Provider Portal is the preferred method for a quicker review.**

### USE THIS FORM FOR (Please select one)

- Treatment Authorization Request for **Psychological Testing**  
↳ Submit with CenCal's Psychological/Neuropsychological Pre-Service Authorization Request Form
- Treatment Authorization Request for **Neuropsychological Testing**  
↳ Submit with CenCal's Psychological/Neuropsychological Pre-Service Authorization Request Form
- Treatment Authorization Requests for **Initial Request to start ABA Treatment**  
↳ Submit with CenCal's Functional Behavioral Assessment Template or an approved template
- Treatment Authorization Request to **Continue ABA Treatment**  
↳ Submit with CenCal's 6 month Progress Report Template or on an approved template AND a signed service log.

**URGENT\*\***    **ROUTINE**    **RETRO\***

**Behavioral Health FAX (805) 681-3070 or send via secure link: <https://gateway.cencalhealth.org/form/bh>**

\*\*\* IN ORDER TO PROCESS YOUR REQUEST, FORM MUST BE COMPLETE AND LEGIBLE \*\*\*

**\*\* URGENT is only when normal time frame for authorization will be detrimental to patient's life or health; jeopardize patient's ability to regain maximum function; or result in loss of life, limb, or other major bodily function. URGENT requests are addressed within 72 hours.**

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
Last First

Member ID# (CIN): \_\_\_\_\_ D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

### REFERRING AND SERVICING PROVIDER INFORMATION

#### Referring Provider:

\_\_\_\_\_

MD NPI#: \_\_\_\_\_ Group NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the Referring Provider the PCP?  YES  NO

#### Provider Rendering Service (Physician, Facility, Vendor):

Required for all submissions, please locate a provider at [CenCalHealth.org](https://gateway.cencalhealth.org) Provider Directory

\_\_\_\_\_

MD NPI#: \_\_\_\_\_ Group NPI#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is the Rendering Provider CCS Paneled?  YES  NO

*Not required for Mental Health Authorization Requests*

To prevent delays, please fax all medical documents to support your request with this form.

[List Procedures Requested on next page](#)

**Behavioral Health Provider Line (805) 562-1600 • Behavioral Health FAX (805) 681-3070**

4050 Calle Real, Santa Barbara, CA 93110

# Behavioral Health



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**LIST ALL PROCEDURES REQUESTED ALONG WITH THE APPROPRIATE CPT/HCPCS (50-1)**

REQUESTED PROCEDURES:	CODE (CPT or HCPCS)	QTY (REQUIRED)	UNITS (REQUIRED)

To prevent delays, please fax all medical documents to support your request with this form.  
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