Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For Autism Spectrum Disorder

<Please Submit to the Dedicated Contract Fax Line Below>

Medicaid

Georgia – 888-871-0590 **Hawaii** – 888-481-9739 **Kentucky** – 877-544-2007 **Illinois** – 855-713-0595
New York – 855-713-0591

Request Type: Initial ☐

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

MEMBER INFORMATION

Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐**Male** ☐**Female**
Third Party Insurance	☐**Yes** ☐ **No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name		**First Name**		**NPI Number**	
WellCare ID Number		**Participating**	☐**Yes** ☐ **No**	**Discipline/ Specialty**	
Street Address		**City, State**		**Zip:**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION

Name		**Facility ID:**		**NPI Number:**	
Street Address		**City, State**		**Zip:**	
Phone Number		**Fax Number**		**Office Contact**	

BOARD CERTIFIED BEHAVIOR ANALYST INFORMATION

For ABA services: Is provider certified to provide ABA – consistent services as defined by State's licensing requirements?
☐ **No** ☐ **Yes** ☐ **N/A per State's licensing requirements**

Have ABA services been ordered by a board certified psychiatrist, psychologist or pediatrician qualified to provide ABA oversight
☐ **No** ☐ **Yes; include copy of BCBA Order**

Name of BCBA professional who will supervise services:		**BCBA certification #**		**Degree / License:**

Requested Services

Service Type Requested	*List CPT Code(s)*	*Number of Units of Each CPT Code Requested*
Applied Behavior Analysis		

Service Request Start Date:

DSM DIAGNOSIS

The following are mandatory fields. ABA service requests will not be processed if the DSM section is not fully completed

Diagnostic	When was the Autism Spectrum diagnosis established? Date:	By whom? (*include full name and credentials*)
Diagnoses DSM 5	☐ Autism Spectrum Disorder ☐ With or without accompanying intellectual impairment ☐ With or without accompanying language	Co-Occurring Diagnoses if applicable:

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	impairment ☐ Associated with a known medical or genetic condition or environmental factor ☐ With catatonia	Psychosocial Barriers if applicable:
Diagnoses DSM IV-TR	Axis I	Member who are < 18 years old must have a diagnosis of one of the following: • Autism Spectrum Disorder • Asperger's Disorder (Asperger syndrome) • Pervasive developmental disorder not otherwise specified (PDD-NOS) • Childhood disintegrative disorder (CDD) • Rett's disorder (Rett syndrome)
	Axis II	
	Axis III	
	Axis IV	
	Axis V	
	Current GAF/CGAS/CAFAS	
	Highest GAF/CAFAS in Past Year	
Medical Problems	☐ No ☐ if Yes; describe	

RATIONALE FOR REQUEST
Where will services occur? ☐ Member's home; ☐ Provider's office • Indicate other POS if applicable to State criteria
Summary of functional capacities and areas of impairment
Assessment and clinical tool(s) used for diagnosis (i.e.: BLA, Preference Assessment, FBA, ABLLS-R, VB-MAPP)
Biopsychosocial summary including household members, environmental factors and medical issues, current educational situation and school services
What type of treatment components will be provided

TREATMENT PLAN	
Area of Concern #1	**(attach baseline level data for each area of concern)**
Behavior / Deficit to Decrease	
Behavior / Skill to Increase	
Methods to be used	
Goals and skills of parent / guardian	
Objective criteria for attainment of goal	
Target date for introduction of goal	
Attainment date of goal	
Care coordination needs	
Interventions emphasizing generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors	
Area of Concern # 2	**(attach baseline level data for each area of concern)**
Behavior / Deficit to Decrease	

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Behavior / Skill to Increase	
Methods to be used	
Goals and skills of parent / guardian	
Objective criteria for attainment of goal	
Target date for introduction of goal	
Attainment date of goal	
Care coordination needs	
Interventions emphasizing generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors	
Area of Concern # 3	**(attach baseline level data for each area of concern)**
Behavior / Deficit to Decrease	
Behavior / Skill to Increase	
Methods to be used	
Goals and skills of parent / guardian	
Objective criteria for attainment of goal	
Target date for introduction of goal	
Attainment date of goal	
Care coordination needs	
Interventions emphasizing generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors	

Attach additional pages if necessary to identify other areas of concern

TRANSITION PLAN

Is the child:

☐ **Beginning treatment**
☐ **Transitioning from a home-based intensive ABA-based program to a lesser level of care**
☐ **Transitioning form a most to least restrictive setting**
☐ **Transitioning from a home-based ABA intervention program to a school-based program**

Projected transition plan / goals:

If clinically necessary, what is the prevention plan and / or resolution of crises, e.g. behavior, consequences, antecedents, de-escalation procedures, prevention, baseline

Is there a crisis plan in place? ☐ No ☐ Yes; what is it?

How will member transition into adulthood

Projected criteria for discharge

Expected discharge date:	**Next level of care:**

END OF FORM