



Treatment Plan Request Form for Autism Spectrum Disorders

Fax Treatment Plans to: 1-866-582-2287

Please print clearly – incomplete or illegible forms may delay processing and may be returned

Please contact the ASD Program at (844) 269-0538 for questions regarding utilization management for Applied Behavioral Analysis.

DEMOGRAPHICS

Member's Name: _____ Member's ID: _____
Date of Birth: _____ Age: _____ Gender: M F
Diagnosis: _____ Dx Date: _____
Diagnosed by Whom: _____

ORDERING PHYSICIAN

Physician Name: _____
Provider TID: _____ Phone: _____
Address: _____
Street City State Zip

AGENCY INFORMATION

Agency Name: _____
TID: _____ NPI: _____ Are you in network with
your local Blue Plan? Yes No
Phone: _____ Fax: _____
Address: _____
Street City State Zip
Contact person / phone (if different than BCBA): _____

BCBA OR RENDERING PROVIDER INFORMATION

Provider Name: _____
TID: _____ NPI: _____ Are you in network with
your local Blue Plan? Yes No
Phone: _____ Fax: _____ Email: _____
Address: _____
Street City State Zip

ASSESSMENT & TREATMENT

For initial assessment requests, please attach:

- Diagnostic evaluation/report completed by a doctorate level clinician
- MD prescription or signed coordination of care letter

Treatment plan should be dated within 30 days of start date

Please ensure the following has been included in your request:

- Cumulative graphs/charts of baseline data and current progress
- Current behavioral support plan and treatment plan including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures and current progress
- Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms including yearly updated evaluation of functioning via standardized tools
- Schedule of treatment (hours per day/week)

ASSESSMENT & TREATMENT (Continued)

- List any other services member is receiving (e.g., PT, OT, ST, school, behavioral health) and coordination of care with other providers
- Documentation of parental involvement and measureable parent goals
- Measurable client specific discharge criteria and transition plan

Age of First ABA Treatment: _____ **Start Date of Current Request:** _____

Adaptive Behavior Treatment	Units	CPT Code	Timeframe (weekly/monthly)
Behavior Identification Assessment (per 15 min)		97151	Per authorization period
Behavior Identification Supporting Assessment (per 15 min)		97152	Per authorization period
Behavior Identification Supporting Assessment (per 15 min), two or more technicians		0362T	Per authorization period
Adaptive Behavior Treatment by Protocol (per 15 min)		97153	
Group Adaptive Behavior Treatment by Protocol (per 15 min)		97154	
Adaptive Behavior Treatment w/ Protocol Modification (per 15 min)		97155	
Family Adaptive Behavior Treatment Guidance (per 15 min)		97156	
Multiple-Family Group Adaptive Behavior Treatment Guidance (per 15 min)		97157	
Adaptive Behavior Treatment Social Skills Group (per 15 min)		97158	
Adaptive Behavior Treatment w/Protocol Modification (per 15 min), two or more technicians		0373T	

Provider Name (print) _____

License Information _____

Provider Signature _____

Date _____

My signature confirms that any paraprofessional under my supervision has the appropriate education and training