



Check one: Initial Request Concurrent Request

Submit forms at least two weeks before requested start date. For any questions, call BCBSTX at 1-866-355-5999. Fax forms to 877-361-7646.

1) For the Initial Treatment Request (ITR)

Submit: Completed Clinical Service Request Form (pages 1-5), Diagnostic Evaluation Report, Provider Baseline and Skills Assessment Instruments and Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)

2) For the Concurrent Treatment Request (CCR)

Submit: Completed Clinical Service Request Form (pages 1-5), Skills Re-Assessment Report and Comprehensive Treatment Plan (additional information may be requested by a clinician once the case is reviewed)

PATIENT INFO

Patient Name Patient Date of Birth Today's Date
Subscriber Name Subscriber ID Group
Patient resides in what state? Services conducted in same state? Yes No If no, what state?

DIAGNOSTIC PRACTITIONER INFO

Diagnostic Practitioner Name NPI
Diagnostic Practitioner Type, if PCP: Family Practice Internal Medicine Pediatrics
Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider: Developmental Behavioral Pediatrics Neurodevelopmental Pediatrics
Child Neurology Adult or Child Psychiatry Licensed Clinical Psychology Other (specify)
Primary Diagnosis Code Secondary Diagnosis Code
Current diagnostic required not older than 36 months.
Initial Evaluation Date Most Recent Evaluation Date

PROVIDER INFO

Rendering Qualified Healthcare Provider (QHP)* Name
*Fill in the Rendering QHP who is directly providing treatment.
NPI Email
Telephone (please provide a number with confidential voicemail) ext
Master's/PhD level clinician/state-recognized professional credential or certification
State License/Cert#
Practice Name
NPI Fax
Address City State Zip Code
Practice Contact Name Telephone ext
Billing Contact Name Telephone ext

CERTIFICATION OF DX & TREATMENT EXPECTATION

I, Diagnostic Practitioner or ABA Services Supervisor (having confirmed with the diagnostician), am recommending ABA services and certify there is a reasonable expectation that this member can actively participate and demonstrates the capacity to learn and develop generalized skills to assist in his/her independence and functional improvements.

Table with 2 columns: Requirements (Line Therapist, ABA Supervisor) and Details (Requirements for line staff, Attestation statement).





Patient Name _____ Patient Date of Birth _____

CERTIFICATION OF PROVIDER QUALIFICATIONS

By signing and returning this form to Blue Cross and Blue Shield, I hereby certify: (1) credentials/license as noted above; (2) the line therapists for whom I, or an outpatient mental health agency or clinic, will bill meet the qualifications set forth above; (3) if staff changes at any time, new staff must meet the same qualifications; (4) time spent meeting the training requirements are not billable to BCBS or BCBS's members and (5) BCBS may, in its discretion, review its claim history or request supporting information in order to verify the accuracy of this certification.

Rendering QHP Signature _____ Date _____

Rendering QHP Printed Name _____ Practice Name _____

PROVIDER TREATMENT REQUEST

Current Request Start Date _____ Requested Service Intensity: Focused Comprehensive

Total Requested Hours Per Week _____

(Note: Re-assessment package, for full clinical assessment, will be authorized every 6 months based on state plan)

ABA Procedure Code Request

Table with 9 columns: Codes, 97151 Assessment, 97152 Assessment, Tech, 97153 Direct Treatment, Tech or QHP, 97155 Protocol Modification & Supervision of Tech QHP, 97154 Group Treatment, Tech, 97158 Group Treatment, QHP, 97156 Family Treatment, QHP, 97157 Multi Family Treatment, QHP. Row 2: Units per 15 minutes

Additional Code(s) Request and Reason

This form must be received within 30 days of the treatment request start date. After that date, claims should be submitted through your normal process and you will receive instructions on how to proceed.

ABA TREATMENT HISTORY

Initial/First Date of ABA Services from current provider/facility _____

Has this member had ABA services with any other provider? No Yes When was the initial date? _____

Intensity of these services: Focused Comprehensive Avg. # of hours/week _____

Continuous ABA services since start? Yes No If break from services, when and why?

Medical History

Sleep Issues Related to ASD? Yes No If yes, please describe

Eating Issues Related to ASD? Yes No If yes, please describe

Is the patient taking medication? Yes No

If yes, prescribed by _____ Professional Licensure/Credential _____

Current Medications (Dosages)



T A B A



Patient Name _____ Patient Date of Birth _____

BASELINE & ASSESSMENT INFO

Date Current Assessment Completed _____ Conducted by (name) _____ License/Cert _____

Assessment must be within the last 30 days.

Assessment Participants: Patient Only Parents/Caregivers Patient and Parents/Caregivers

Please select one (1) instrument that will be utilized for the member's entire treatment episode so progress can effectively be measured. Choose a recognized instrument such as the VB MAPP, ABLLS, AFLS, ABAS or the Vineland. Also, please attach standardized measurement scoring summaries if the member has been in treatment prior to this request.

Table with 5 columns: Name of Assessment Instrument, Current Test Date, Current Score, Previous Test Date, Previous Test Score. Two empty rows for data entry.

CURRENT MALADAPTIVE BEHAVIORS

- (1) Behavior _____ Freq _____ per hour session day or week
(2) Behavior _____ Freq _____ per hour session day or week
(3) Behavior _____ Freq _____ per hour session day or week
(4) Behavior _____ Freq _____ per hour session day or week

MEMBER TREATMENT PLAN

Table with 2 columns: Member Skill Acquisition Goals (focusing on the development of spontaneous social communications, adaptive skills and appropriate behaviors), Enter Total Number. Rows include New goals, Goals carried over from previous authorization period, Goals on hold, Goals mastered during the previous authorization period, and Other (describe):





Patient Name _____ Patient Date of Birth _____

PARENT INVOLVEMENT

The parent/caregiver is expected to participate in training sessions _____ hours per week.

	Intro Date	Baseline (%)	Measurable Parent Training Goals	Current Progress/Data (%)	Expected Mastery Date
1					
2					
3					

TREATMENT FADE/ TRANSITION/ DISCHARGE PLAN

Member's Fade Plan: Member will step down from current _____ hrs/week to _____ hrs/week, on date _____ or within _____ months.

Measurable Fade Plan with Criteria

Discharge Plan with Objective and Measurable Criteria

Other referrals/supports recommended at time of discharge

Parent/Caregiver in agreement? Yes No





Patient Name _____ Patient Date of Birth _____

Member ABA Schedule			
Day of Week	Time Span	Location	Lunch / Breaks
Monday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Tuesday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Wednesday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Thursday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Friday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Saturday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
Sunday	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		

Member School and Other Therapy Schedule	
Day of Week	Time Span
Monday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Tuesday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Wednesday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Thursday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Friday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Saturday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
Sunday	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___

Supports Outside ABA Treatment	Member accessing other school program? <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify) _____
	Member has IEP, ISP, 504 or ARD in place? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?
	Is this member accessing other therapeutic services? <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational <input type="checkbox"/> Speech <input type="checkbox"/> NA
	Is there coordination of care with other medical or BH providers? <input type="checkbox"/> Yes <input type="checkbox"/> No; Those are _____

