



Check one:  Initial Request  Concurrent Request

Submit forms at least two weeks before requested start date. For any questions, call BCBSTX at 800-528-7264. 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 providing 1:1 therapy, As the ABA Supervisor (above), I attest that I follow outlined guidelines for supervision by the BACB and have an active license in the state where this member's services are rendered.)





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)





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
<b>Monday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Tuesday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Wednesday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Thursday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Friday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Saturday</b>	Time ___:___ to ___:___	<input type="checkbox"/> Office <input type="checkbox"/> Home	
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
	Time ___:___ to ___:___		
<b>Sunday</b>	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
<b>Monday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Tuesday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Wednesday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Thursday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Friday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Saturday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
<b>Sunday</b>	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___
	Time ___:___ to ___:___

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

