BlueCross BlueShield of Texas

Applied Behavior Analysis (ABA)

Initial Assessment Request

For any questions, call BCBSTX at 800-528-7264 or BCBSTX FEP at 800-528-7264. Fax Forms to 877-361-7646.

PATIENT INFO

Patient Name _____ **Patient Date of Birth** _____ **Request Submission 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** _____

Telephone _____ **Fax** _____ **Contact Name** _____

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** _____ **Dates of Initial Evaluations** _____ / _____ / _____

AUTHORIZATION/COMMUNICATION SENT TO

Facility Name _____ **NPI** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Telephone _____ **ext** _____ **Fax** _____ **Contact Name** _____

BCBA Name _____ **NPI** _____ **License/Cert** _____

Address (if not same as above) _____ **City** _____ **State** _____ **Zip Code** _____

Telephone _____ **ext** _____ **Fax** _____ **Contact Name** _____

PROVIDER REQUEST

Assessment Request Start Date _____ / _____ / _____ **to End Date** _____ / _____ / _____

ABA Assessment Code Request (Total Units for Assessment Period; 1 Unit = 15 minutes)	**97151** QHP	**97152** Technician

Additional Code(s) Request and Reason

CERTIFICATION OF PROVIDER QUALIFICATIONS

ABA Supervisor Signature _____ **Date** _____ / _____ / _____

ABA Supervisor Printed Name _____ **Clinic Name** _____

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