

Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For Autism Spectrum Disorder

Medicaid
South Carolina – 1-888-343-5364

Place of Service	<input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 22-Outpatient Hospital <input type="checkbox"/> 53-Community Mental Health Center <input type="checkbox"/> Other (provide code)-_____
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MEMBER INFORMATION

Last Name	First Name, Middle Initial	Date of Birth	
Phone Number	WellCare ID Number	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Third Party Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	
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REQUESTED SERVICES

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

Service Request Start Date:

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Proudly serving *Healthy Connections* members.

DIAGNOSIS		
The following are mandatory fields. ABA service requests will not be processed if the diagnostic section is not fully completed.		
Diagnosis Information	When was the Autism Spectrum diagnosis established? Date:	By whom?(include full name and credentials)
Assessment Information	When did the most recent assessment occur?	Current IQ level:
DSM or ICD Diagnosis	<input type="checkbox"/> Autism Spectrum Disorder <ul style="list-style-type: none"> <input type="checkbox"/> With or without accompanying intellectual impairment <input type="checkbox"/> With or without accompanying language impairment <input type="checkbox"/> Associated with a known medical or genetic condition or environmental factor <input type="checkbox"/> With catatonia 	Members who are < 18 years old must have a diagnosis of one of the following: <ul style="list-style-type: none"> • Autism Spectrum Disorder (Level 1, Level 2, or Level 3) • Social (Pragmatic) Communication Disorder • Or, a previous DSM IV diagnosis of one of the following: <ul style="list-style-type: none"> ○ Asperger's Disorder (Asperger Syndrome) ○ Pervasive Developmental Disorder, not otherwise specified ○ Childhood Disintegrative Disorder (CDD) ○ Rett Disorder (Rett Syndrome)
	Primary	Psychosocial Barrier, if applicable:
	Secondary	Co-occurring Diagnosis, if applicable:
	Medical	
RATIONALE FOR REQUEST AND TREATMENT HISTORY		
Summary of function capacities and areas of impairment		
Assessment and clinical tool(s) used for diagnosis (i.e., BLA, Preference Assessment, FBA, ABLL S-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?		

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Current Psychotropic Medications (if applicable):

Medication Name:	Dosage:

Please explain the current treatment modalities and services in place:

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	

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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	
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	

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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:	
<input type="checkbox"/> Beginning treatment <input type="checkbox"/> Transitioning from a home-based intensive ABA-based program to a lesser level of care <input type="checkbox"/> Transitioning from a most to least restrictive setting <input type="checkbox"/> Transitioning from a home-based ABA intervention program to a school-based program	
Projected transition plan/goals:	
If clinically necessary, what are the prevention plan and/or resolution of crises? (i.e., behavior, consequences, antecedents, de-escalation procedures, prevention, baseline)	
Is there a crisis plan in place? <input type="checkbox"/> No <input type="checkbox"/> Yes: What is it?	
How will member transition into adulthood?	
Projected criteria for discharge:	
Expected discharge date:	Next level of care:

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Behavior/Deficit to Decrease	
Behavior/Skill to Increase	
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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	
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