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Applied Behavior Analysis Service Request Form For Initial Assessment and Treatment

Please fax this completed form to: 617-246-4281
For BCBSMA employees and dependents, fax to 1-888-608-3693

Is this an initial assessment request? ❒ if yes, then… Complete sections **A** and **B** only
Is this a treatment request? ❒ if yes, then… Complete sections **A, C,** and **D**

Section A. Member and agency Information

Member name:		Requested auth start date:	
Member ID#:		Date of birth:	
		Age:	

Name of Licensed Applied Behavior Analyst (LABA) :		LABA license #:	
Agency name:		Agency NPI:	
Agency address:		Agency phone #:	
City, State, ZIP:		Agency fax #:	
Contact person at agency:		Contact phone #:	

Section B. Initial assessment request only

How many **hours** and **units** are you requesting **for CPT 97151 - assessment** (must meet Autism payment policy requirements) by the LABA Hours: Units:

Note: **CPT 97151 is not reimbursed for behavior technicians**

Please attach a letter dated within the last 6 months and signed by a licensed physician or licensed psychologist that includes:

- an autism diagnosis, and
- a recommendation of ABA services.

Section C. Service information

Does the agency named in Section A employ or reimburse behavior technician for ABA services? ❒ Yes ❒ No

If no, please explain:

Has everyone who works with the member and their family completed a background check? (CORI/SORI)? ❒ Yes ❒ No

If no, please explain:

If a behavior technician is employed, has he/she received specific ABA-related training? ❒ Yes ❒ No

If yes, # of hours?

Member's diagnosis:

continued

Patient name:		Requested authorization start date:	
Member ID#:		Date of birth:	

Section C. Service information, *continued*

Indicate services the member receives from other providers, including Individualized Education Program (IEP) services.

Provider type		Hours/week	Does this provider collaborate with Licensed Applied Behavior Analyst ?	If no, please explain:
Occupational therapist	❒ Yes ❒ No		❒ Yes ❒ No	
Physical therapist	❒ Yes ❒ No		❒ Yes ❒ No	
Speech therapist	❒ Yes ❒ No		❒ Yes ❒ No	
Mental health provider(s)	❒ Yes ❒ No		❒ Yes ❒ No	
Pediatrician/primary care	❒ Yes ❒ No		❒ Yes ❒ No	
How many hours per week is the member in school/pre-school/early intervention?				

Please provide information on number of ABA service hours per day and location of services.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Location H = home O = office C = community							
How many hours?							

Use the table below to indicate **hours** and **units per week** of services requested (must meet Autism payment policy requirements). **All units are in 15 minute increments.**

Code	Services rendered by a			
	…..LABA		…behavior technician	
	Hours	Units	Hours	Units
0362T (per authorization)			not required	
0373T			not required	
97151 (per authorization)			not reimbursed	
97152 (per authorization)				
97153				

Code	Services rendered by a			
	….LABA		….behavior technician	
	Hours	Units	Hours	Units
97154				
97155			not reimbursed	
97156			not reimbursed	
97157			not reimbursed	
97158			not reimbursed	

Section D. Treatment plan

Please attach an individualized, updated treatment plan (see Autism Services payment policy>Related Policies>Treatment Plan Guidelines for Applied Behavior Analysis). The plan should include:

- measurable goals,
- data related to progress within individual treatment goals,
- goal status (met, progressing, regressing), and
- plan for supervision.