



Check one: Initial Request Concurrent Request

For any questions, call BCBSOK at 800-672-2378 or BCBSOK FEP at 877-906-6389

Fax Forms to 877-361-7660

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 Dates of Evaluations: Initial Follow Up

BCBA, BCBA-D, PROFESSIONALLY LICENSED PRACTITIONER INFO

ABA/Team Supervisor Name License/Cert #

Team Supervisor Certification and/or License (check what applies):

Certified through the Behavior Analyst Certification Board (BACB): BCBA BCBA-D

Professional Licensed Practitioners (minimum of six months specialized training): Licensed Clinical Psychology (PhD)

Other Licensure

Master's level clinician/state-recognized professional credential or certification State

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.

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.

ABA Supervisor Signature Date

ABA Supervisor Printed Name Clinic Name





Patient Name _____ Patient Date of Birth _____

PROVIDER INFO

Facility Name _____ NPI _____
Address _____ City _____ State _____ Zip Code _____
Telephone _____ ext _____ Fax _____ Contact Name _____

Rendering BCBA Name _____ License/Cert # _____ NPI _____
Address (if not same as above) _____ City _____ State _____ Zip Code _____
Telephone _____ ext _____ Fax _____

PROVIDER TREATMENT REQUEST

Treatment 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)

Table with 8 columns: ABA Procedure Code Request, Codes, 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. Includes a row for Units per 15 minutes.

Additional Code(s) Request and Reason

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 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.

Name of Assessment Instrument	Current Test Date	Current Score	Previous Test Date	Previous Test Score
	____/____/____		____/____/____	
Name of Assessment Instrument	Current Test Date	Current Score	Previous Test Date	Previous Test Score
	____/____/____		____/____/____	

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

	Intro Date	Baseline (%)	Measurable Member Treatment Goals (Goals from Different Domains)	Current Progress/Data (%)	Expected Mastery Date
1					
2					
3					
4					
5					





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 Member Treatment 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

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 ___:___		
	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 ___:___		

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 _____
Is the family accessing community supports? <input type="checkbox"/> Yes <input type="checkbox"/> No Which ones _____	

My signature confirms that I am providing/supervising the requested ABA services:

ABA Supervisor Signature _____ Date _____
ABA Supervisor Printed Name _____ Clinic Name _____

