

Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For
Autism Spectrum Disorder

Please Submit to the Dedicated Fax Line Below

New Jersey Medicaid

1-888-339-2677

Place of Service 11- Office 12- Home 22- Outpatient Hospital 53- Community Mental Health Center Other – provide code

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 Code
Phone Number	Fax Number	Office Contact

FACILITY/AGENCY INFORMATION

Name	Facility ID	NPI Number
Street Address	City, State	Zip Code
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

Is supervision planned? No Yes Unknown

If yes, both of the following are required:

Planned supervision of case with greater than or equal to 4 supervision sessions per month **OR** greater than or equal to 1 hour of supervision per 15 hours of direct treatment.

Direct or video-based supervision planned greater than or equal to 1 time every 2 weeks **OR** greater than or equal to 1 hour per 30 hours of direct treatment.

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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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? <i>(include full name and credentials)</i>
Assessment Information	When did the most recent assessment occur?	Current IQ level:
DSM or ICD Diagnosis	<input type="checkbox"/> Autism Spectrum Disorder <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's Disorder (Rett's 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?

Current Psychotropic Medications (if applicable):

Medication Name	Dosage:

Please explain the current treatment modalities and services in place:

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<p>Is the member in school?</p> <p><input type="checkbox"/> Enrolled in school <input type="checkbox"/> Enrolled in preschool <input type="checkbox"/> Enrolled in early intervention program <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Is not enrolled in school, preschool, or early intervention program</p> <p>School attendance: <input type="checkbox"/> Attends full days <input type="checkbox"/> Attends half days <input type="checkbox"/> Unknown</p>

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	
Interventions emphasizing generalization of skills and focus on the development of spontaneous social communication, adaptive skills, and appropriate behaviors	

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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	
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: