WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Applied Behavior Analysis (ABA) For Autism Spectrum Disorder

Medicaid
Kentucky – 1-877-544-2007

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**	☐ Male ☐ Female
Third Party Insurance	☐ Yes ☐ 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**	☐ Yes ☐ 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:**

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?(*include full name and credentials*)**
Assessment Information	**When did the most recent assessment occur?**	**Current IQ level:**
DSM or ICD Diagnosis	☐ **Autism Spectrum Disorder** ☐ **With or without accompanying intellectual impairment** ☐ **With or without accompanying language impairment** ☐ **Associated with a known medical or genetic condition or environmental factor** ☐ **With catatonia**	**Members who are < 18 years old must have a diagnosis of one of the following:** • **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:** ○ **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	
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	

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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:

- ☐ Beginning treatment
- ☐ Transitioning from a home-based intensive ABA-based program to a lesser level of care
- ☐ Transitioning from a most to least restrictive setting
- ☐ 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? ☐ **No** ☐ **Yes: What is it?**

How will member transition into adulthood?

Projected criteria for discharge:	
Expected discharge date:	**Next level of care:**