Healthy Blue | HERITAGE HEALTH

# *Treatment Plan Request Form for Autism Spectrum Disorders*

**Please print clearly. Incomplete or illegible forms may delay processing and may be returned. Please submit this form electronically using our preferred method at https://www.availity.com.* You may also submit via fax to 1-844-462-0027. Please submit on the last authorized day.**

| | | | | | |
|---|---|---|---|---|---|
| **Date** | | | | | |
| **Demographics** | | | | | |
| **Member's name** | | **Member ID** | | | |
| **Date of birth** | | **Age** | | **Gender** | |
| **Diagnosis** | | **Dx date** | | | |
| **Diagnosed by whom** | | | | | |
| **ORDERING PHYSICIAN** | | | | | |
| **Physician name** | | **Provider TID** | | | |
| **Address** | | **Phone** | | | |
| **AGENCY INFORMATION** | | | | | |
| **Agency name** | | **TID** | | | |
| **NPI** | | **Contact person/phone *(if different than BCBA)*:** | | | |
| **Phone** | | **Fax** | | | |
| **Address** | | | | | |
| **BCBA OR RENDERING PROVIDER INFORMATION** | | | | | |
| **Provider name** | | **TID** | | | |
| **NPI** | | **Email** | | | |
| **Phone** | | **Fax** | | | |
| **Address** | | | | | |
| **ASSESSMENT and TREATMENT** | | | | | |
| For initial assessment requests, please attach: | | | | | |

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

**https://provider.healthybluene.com**

- Diagnostic evaluation/report completed by a doctorate-level clinician.
- MD prescription or signed coordination of care letter.

**Treatment plan should be dated within 30 days of start date.**

**Please ensure the following has been included in your request:**

- Cumulative graphs/charts of baseline data and current progress
- Current behavioral support plan and treatment plan including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures and current progress
- Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms including yearly updated evaluation of functioning via standardized tools
- List any other services member is receiving (for example, PT, OT, ST, school, behavioral health) and coordination of care with other providers
- Schedule of treatment (hours per day/week)
- Documentation of parental involvement and measureable parent goals

| **Measurable client-specific discharge criteria and transition plan** | | | |
|---|---|---|---|
| **Age of first ABA treatment** | | **Start date of current request** | |
| **Adaptive behavior treatment** | **Units** | **CPT® code** | **Time frame (weekly/monthly)** |
| Behavior Identification Assessment (per 15 min) | | 97151 | Per authorization period |
| Behavior Identification Supporting Assessment (per 15 min) | | 97152 | Per authorization period |
| Adaptive Behavior Treatment by Protocol (per 15 min) | | 97153 | |
| Group Adaptive Behavior Treatment by Protocol (per 15 min) | | 97154 | |
| Adaptive Behavior Treatment w/Protocol Modification (per 15 min) | | 97155 | |
| Family Adaptive Behavior Treatment Guidance (per 15 min) | | 97156 | |
| Adaptive Behavior Treatment Social Skills Group (per 15 min) | | 97158 | |

| | | | |
|---|---|---|---|
| **Provider name (print)** | | **License information** | |
| **Provider signature** | | **Date** | |
| **My signature confirms that any paraprofessional under my supervision has the appropriate education and training.** | | | |