of Tennessee

Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorder

Assessment, Initiation and Continuation Request Form for ABA Therapy Services

Complete all fields and fax to: 1-800-496-9600

*** Any additional documentation to support request may be attached to this form (optional)**

Member Name: _____ Date of Birth: _____

Member Identification Number: _____

Member Parent's/Guardian's Name: _____

Member Current Telephone Number: _____

Provider of ABA Services Name: _____

Address: _____

City: _____ ZIP Code: _____

Phone Number: _____ Fax Number: _____

Provider ID or NPI Number: _____

☐ Diagnosis and Severity Level: _____
Diagnostic confirmation is required. (i.e., Diagnostic report, doctor's order, etc.)

☐ Level 1 ☐ Level 2 ☐ Level 3

Prior therapies (e.g. Clinical Child & Family Therapy, Residential Treatment, or previous ABA therapies). Most recent date span(s):

Improvement(s) expected in the individual's behavior with ABA therapy:

Parent/caregiver has been identified and is available to participate in the ABA therapy program:

☐ Name: _____

Relationship to Member: _____

Living Arrangements: _____

Member attends and/or participates in early intervention program; pre-school; school on what basis:

☐ Full time ☐ Part time ☐ Not enrolled

☐ Not able to attend (explain): _____

Medical Conditions: _____

ABA therapy will be provided between the qualified practitioner and the individual member and/or caregiver at the following proposed location(s):

Certification Period

ABA Therapy will begin:_____

ABA Therapy will end: _____

Complete this section for an Assessment for ABA Therapy Services

Code	Service Description	Hours per Week

Provider Signature: _____

Provider Name: _____

Credentials: _____ Date: _____

Complete this section for Initiation/Continuation of ABA Therapy

Requests for continuation of ABA services must be submitted at least once every 6 months.

The hours per week authorized are not inclusive of other services being provided (e.g. occupational therapy, physical therapy).

If this request is for a continuation of ABA therapy already begun, does the individual continue to exhibit symptoms/ behaviors that:

Are a safety risk to self, others or property? Explain:

Prevent adequate participation in age appropriate home, school or community activities? Explain:

If this request is for a continuation of ABA therapy already begun, has measurable progress been made toward goals and are they documented in the member's ABA therapy treatment plan?

☐ Yes ☐ No, explain: If this request is for a continuation of ABA therapy already

If this request is for a continuation of ABA therapy already begun, can progress be maintained if ABA therapy is reduced or discontinued?

☐ Yes ☐ No, explain why:

ABA Treatment History

Initial/First Date ASD Diagnosed: _____

Has this member had ABA services with any other provider?

☐ Yes ☐ No If yes, first ABA treatment start date?_____

Intensity of these services?

☐ Focused ☐ Comprehensive ☐ Avgerage number of hours/week _____

Continuous ABA services since start?

☐ Yes ☐ No

If break from services, then when and why?

List accomplishments from prior ABA services?

Please provide measurable goals that will define improvement

Existing goals with progress:

New proposed goals:

Parent/Caregiver involvement:

Complete this section for Initiation/Continuation of Treatment for ABA Therapy Services

Certification Period (6 months/26 weeks authorization period)

ABA Therapy will begin:_____ ABA Therapy will end: _____

Code	Service Description	Hours per Week

Clinical Justification for increase in hours of service:

If concurrent, _____number of hours were approved during the last

authorization period; _____number of hours used by the member.

Assessment and Initiation/Continuation of Treatment for ABA therapy is subject to prior approval, however prior approval is not a confirmation of coverage or benefits. Payment will be subject to all other policy provisions. The hours per week authorized are not inclusive of other services being provided (e.g. occupational therapy, physical therapy).

I attest to the accuracy and completeness of all information on this form:

Provider's Signature: _____ Date:_____

Provider's Printed Name: _____

Credentials: _____

If attachments are included, please submit in black and white for review.

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