BlueCross BlueShield of Montana

Applied Behavior Analysis

Clinical Service Request Form

Check one: ☐ Initial Request ☐ Concurrent Request

Submit forms at least two weeks before requested start date.
For any questions, call Blue Cross and Blue Shield of Montana at 800-851-7498 or BCBSMT Federal Employee Program® at 800-779-4602. Fax forms to 855-649-9681.

1) **For the Initial Treatment Request**
   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**
   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? _____

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** _____

Current diagnostic required not older than 36 months.

Initial Evaluation Date _____ **Most Recent Evaluation Date** _____

PROVIDER INFO

Rendering Qualified Healthcare Provider (QHP)* Name _____

**Fill in the Rendering QHP who is directly providing treatment.*

NPI _____ **Email** _____

Telephone *(please provide a number with confidential voicemail)* _____ **ext** _____

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

State _____ **License/Cert#** _____

Clinic Practice Name _____

NPI _____ **Fax** _____

Clinic Practice Rendering Provider Address _____ **City** _____ **State** _____ **Zip Code** _____

Practice Contact Name _____ **Telephone** _____ **ext** _____

Admin Billing Office Address _____

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.

Line Therapist Requirements	**Requirements for line staff providing 1:1 therapy:** 1) 18+ years of age; 2) High school diploma or GED; 3) criminal background check prior to active employment; 4) via practice expense, completed training of ASD and behavioral related subjects/evidence based techniques (40 hours) and 5) have on-going supervisory oversight by the BCBA or ABA treatment supervisor for a minimum of 5% of hours directly worked with members.
ABA Supervisor Requirements	**As the ABA Supervisor (above), I attest** that I follow outlined guidelines for supervision by the BACB and have an active license in the state where this member's services are rendered. ☐ Yes ☐ No

Patient Name _____ Patient Date of Birth _____

CERTIFICATION OF PROVIDER QUALIFICATIONS

By signing and returning this form to Blue Cross and Blue Shield of Montana, 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 BCBSMT or members of BCBSMT and (5) BCBSMT may, in its discretion, review its claim history or request supporting information in order to verify the accuracy of this certification.

I accept the number of units/days the clinical team determines is medically necessary and appropriate based on clinical submitted. Yes ☐ No ☐

Rendering QHP Signature _____ **Date** _____

Rendering QHP Printed Name _____ **Practice Name** _____

PROVIDER TREATMENT REQUEST

Current 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)

ABA Procedure Code Request

Codes	**97151** Assessment **QHP**	**97152** Assessment, **Tech**	**97153** Direct Treatment, **Tech** or **QHP**	**97155** Protocol Modification & Supervision of Tech **QHP**	**97154** Group Treatment, **Tech** or **QHP**	**97158** Group Protocol Modification **QHP**	**97156** Family Treatment, **QHP**	**97157** Multi Family Treatment, **QHP**
Units per 15 minutes								

Additional Code(s) Request and Reason

ABA services require prior authorization. This form must be received within 30 days prior to the treatment request start date. For forms submitted after the requested start date, claims should be submitted through your normal process and you will receive instructions on how to proceed.

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)

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Patient Name _____ Patient Date of Birth _____

BASELINE & ASSESSMENT INFO

Date Current Assessment Completed _____ **Conducted by (name)** _____ **License/Cert** _____
Assessment must be within the last 30 days.

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

Member Skill Acquisition Goals (focusing on the development of spontaneous social communications, adaptive skills and appropriate behaviors)	**Enter Total Number**
New goals	
Goals carried over from previous authorization period	
Goals on hold	
Goals mastered during the previous authorization period	
Other (describe):	

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 Parent Training 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 with Objective and Measurable Criteria

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 ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Tuesday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Wednesday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Thursday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Friday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Saturday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	
Sunday	Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____ Time ___:_____ to ___:_____	☐ Office/Clinic ☐ Home ☐ Community/ Daycare ☐ School ☐ Other_____	

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? ☐ Public ☐ Private ☐ Home ☐ Other (Specify) _____ **Member has IEP, ISP, 504 or ARD in place?** ☐ Yes ☐ No If no, why not? **Is this member accessing other therapeutic services?** ☐ Physical Therapy ☐ Occupational ☐ Speech ☐ NA **Is there coordination of care with other medical or BH providers?** ☐ Yes ☐ No; Those are _____

Please submit any relevant clinical information to support the services rendered at a location other than office or home. Add this information to the first page of the attached clinical documentation.

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