



Check one:  Initial Request  Concurrent Request

For any questions, call BCBSIL BCCHP at 877-860-2837 or BCBSIL MMAI at 877-723-7702 Fax Forms to 312-233-4099

1) For the Initial Treatment Request (ITR)

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 (CCR)

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? Services conducted in same state? Yes No If no, 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 Dates of Evaluations: Initial Follow Up

BCBA, BCBA-D, PROFESSIONALLY LICENSED PRACTITIONER INFO

ABA/Team Supervisor Name License/Cert #
Team Supervisor Certification and/or License (check what applies):
Certified through the Behavior Analyst Certification Board (BACB): BCBA BCBA-D
Professional Licensed Practitioners (minimum of six months specialized training): Licensed Clinical Psychology (PhD)
Other Licensure
Master's level clinician/state-recognized professional credential or certification State

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.

Table with 2 columns: Requirements and text. Row 1: 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... Row 2: 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.

CERTIFICATION OF PROVIDER QUALIFICATIONS

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

ABA Supervisor Signature Date
ABA Supervisor Printed Name Clinic Name





Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

PROVIDER INFO

Facility Name \_\_\_\_\_ NPI \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Telephone \_\_\_\_\_ ext \_\_\_\_\_ Fax \_\_\_\_\_ Contact Name \_\_\_\_\_

Rendering BCBA Name \_\_\_\_\_ License/Cert # \_\_\_\_\_ NPI \_\_\_\_\_
Address (if not same as above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
Telephone \_\_\_\_\_ ext \_\_\_\_\_ Fax \_\_\_\_\_

PROVIDER TREATMENT REQUEST

Treatment 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)

Table with 8 columns: ABA Procedure Code Request, Codes, 97153 Direct Treatment, Tech or QHP, 97155 Protocol Modification & Supervision of Tech QHP, 97154 Group Treatment, Tech, 97158 Group Treatment, QHP, 97156 Family Treatment, QHP, 97157 Multi Family Treatment, QHP. Includes a row for Units per 15 minutes.

Additional Code(s) Request and Reason

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)





Patient Name \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

**BASELINE & ASSESSMENT INFO**

Date Current Assessment Completed \_\_\_\_/\_\_\_\_/\_\_\_\_ Conducted by (name) \_\_\_\_\_ License/Cert \_\_\_\_\_

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**

	Intro Date	Baseline (%)	Measurable Member Treatment Goals (Goals from Different Domains)	Current Progress/Data (%)	Expected Mastery Date
1					
2					
3					
4					
5					





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 Member Treatment 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**

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 ___:___		
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 ___:___		

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 ___:___

<b>Supports Outside ABA Treatment</b>	<b>Member accessing other school program?</b> <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify) _____
	<b>Member has IEP, ISP, 504 or ARD in place?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____
	<b>Is this member accessing other therapeutic services?</b> <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational <input type="checkbox"/> Speech <input type="checkbox"/> NA
	<b>Is there coordination of care with other medical or BH providers?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No; Those are _____
<b>Is the family accessing community supports?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Which ones _____	

My signature confirms that I am providing/supervising the requested ABA services:

ABA Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

ABA Supervisor Printed Name \_\_\_\_\_ Clinic Name \_\_\_\_\_

