BlueCross BlueShield of Illinois

Applied Behavior Analysis (ABA)

Clinical Service Request Form

Check one: ☐ **Initial Request** ☒ **Concurrent Request**

For any questions, call BCBSIL at 800-851-7498 or BCBSIL FEP at 800-779-4602 **Fax Forms to 877-361-7656**

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.

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 & 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

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** _____

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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)

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**
	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)

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Patient Name _____ Patient Date of Birth _____

BASELINE & ASSESSMENT INFO

Date Current Assessment Completed 02` / 16 / 2019 **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 Score**	**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 ___:___ ___

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 _____

Is the family accessing community supports? ☐ Yes ☐ 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 _____