



For any questions, call Blue Cross and Blue Shield of Illinois (BCBSIL) at 800-851-7498 or BCBSIL FEP at 800-779-4602. Fax Form to 877-361-7656. Instructions: Please complete this form to have your request reviewed.

PROVIDER INFO

Provider/Agency Name NPI Request Submission Date BCBA Supervisor Name NPI Professional Level Provider resident state Has the Provider met state practice regulations/requirements? Services conducted in same state?

PATIENT INFO

Patient Name Date of Birth Request Submission Date Subscriber Name Subscriber Group

TELEHEALTH REQUIREMENTS

- Provider/BCBA has/will be submitted clinical documentation so a determination for medical necessity for this member for ABA services has been/can be made. Provider/BCBA can provide documentation to support that this member is in a rural Health Professional Shortage Area (HPSA), or this member meets the standards for telehealth supervision outlined in the Applied Behavior Analysis and Telehealth Supervision document. Provider/BCBA has/will be been informed of their rights and responsibilities regarding this requested service and member written consent specific to participation in telehealth supervision has been obtained. Provider/BCBA has written protocols to ensure telehealth supervision meets state/federal laws, established member care standards and privacy and confidentiality (HIPAA) standards regarding electronic record transmission. Provider/BCBA has availability of high quality video/audio equipment, up to date security software, and real time interactive connectivity using internet-based conferencing software programs. Provider/BCBA has written protocols for management of urgent/emergent situations. Provider/BCBA will maintain timely, complete records of all telehealth services provided to member. Provider/BCBA will arrange for the functional assessment every six months to be 'face to face' for quality treatment planning to occur.

ATTESTATION

I plan on providing ABA supervision via telehealth to BCBSIL member starting I have read the document titled Applied Behavior Analysis and Telehealth Supervision and meet all requirements for delivery of these supervision services via telehealth. I attest by my signature below that my professional license and practice meets all state, federal laws and criteria. I understand that it is my responsibility to comply with all BCBSIL, state & federal telehealth regulations and guidelines. I hereby certify that my representations contained in this document are true and accurate. I further understand that any information entered on this attestation document that is subsequently found to be false could result in termination of any agreement I have or entered with BCBSIL.

I understand and agree that, as a part of the process for delivery of telehealth services, I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and/or experience, clinical competence, telehealth requirements or standards that must be met, or any other criteria used by BCBSIL for determining initial and ongoing eligibility participation for these services. I acknowledge that the information obtained relating to this process will be held confidential to the extent permitted by law.

ABA Supervisor Signature: ABA Supervisor Printed Name: Date: Clinic Name:

