Treatment Plan Request Form for Autism Spectrum Disorders

Please submit this form electronically using our preferred method at **Availity.com**.* You may also submit via fax to **844-442-8007**. If this is for concurrent review, the request is due on or before the last authorized day. Make sure to type or print clearly — incomplete or illegible forms may delay processing and may be returned.

Date:		
Demographics		
Member name:		Member ID:
Date of birth:	Age:	Gender: ☐ M ☐ F
Diagnosis:		Diagnosis date:
Diagnosed by whom:		
Ordering physician		
Physician name:		
Provider tax ID:		Phone:
Address:		
Agency information		
Agency name:		
Tax ID:		NPI:
Are you in-network with Amerigroup Community Care? ☐ Yes ☐ No		
Phone:		Fax:
Address:		
Contact person/phone (if different than board certified behavior analyst [BCBA]):		
BCBA or licensed rendering provider information		
Provider name:		
Tax ID:		NPI:
Phone:		Fax:
Address:		
Email:		
Assessment and treatment		
For initial assessment requests, please attach: • Diagnostic evaluation/report completed by a qualified health professional. • MD prescription or signed coordination of care letter.		

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

Assessment and treatment (cont.)

Treatment plan should be dated within 30 days of start date.
Ensure the following is included in your request:

- Cumulative graphs/charts of baseline data and current progress.
- Current behavioral support plan and treatment plan, including symptoms and behaviors requiring treatment, skills to be addressed, baseline measures, and current progress.
- Description of desired outcomes/alleviation of problems and/or symptoms in specific, behavioral, and measurable terms, including yearly updated evaluation of functioning via standardized tools.
- List of any other services member is receiving (for example, PT, OT, ST, school, behavioral health) and coordination of care with other providers.
- Schedule of treatment (hours per day/week).
- Documentation of parental involvement and measurable parent goals.
- Measurable client-specific discharge criteria and transition plan.

Age of first autism treatment (ABA/DIR):

Start date of current request:

Adaptive behavior treatment (ABA)	**Units**	**CPT® code**	**Time frame (weekly/monthly)**
Behavior identification assessment (per 15 min)		97151	
Behavior identification supporting assessment (per 15 min)		97152	
Behavior identification supporting assessment (per 15 min), two or more technicians		0362T	
Adaptive behavior treatment by protocol (per 15 min)		97153	
Group adaptive behavior treatment by protocol (per 15 min)		97154	
Adaptive behavior treatment w/protocol modification (per 15 min)		97155	
Family adaptive behavior treatment guidance (per 15 min)		97156	
Multiple-family group adaptive behavior treatment guidance (per 15 min)		97157	
Adaptive behavior treatment social skills group (per 15 min)		97158	
Adaptive behavior treatment w/protocol modification (per 15 min), two or more technicians		0373T	
Developmental individual-difference relationship-based (DIR)	**Units**	**CPT code**	**Time frame (weekly/monthly)**
Health behavior assessment or re-assessment		96156 EP	
Supervision, treatment plan modification		96156 EP 26	
Health behavior intervention, initial 30 mins		96158 EP	
Health behavior intervention, each additional 15 mins		96159 EP	
Health behavior intervention, initial 30 mins		96164 EP	
Health behavior intervention, each additional 15 mins		96165 EP	
Health behavior intervention, family, initial 30 mins		96167 EP	
Health behavior intervention, family, each additional 15 mins		96168 EP	
Health behavior intervention, initial 30 mins		96170 EP	