



# Applied Behavior Analysis Service Request Form For Initial Assessment and Treatment

Please fax this completed form to: 617-246-4281  
For BCBSMA employees and dependents, fax to 1-888-608-3693

Is this an initial assessment request?  if yes, then... Complete sections **A** and **B** only  
Is this a treatment request?  if yes, then... Complete sections **A, C,** and **D**

## Section A. Member and agency Information

Member name:	<input type="text"/>	Requested auth start date:	<input type="text"/>
Member ID#:	<input type="text"/>	Date of birth:	<input type="text"/>
		Age:	<input type="text"/>
Name of Licensed Applied Behavioral Analyst (LABA):	<input type="text"/>	LABA license #:	<input type="text"/>
Agency name:	<input type="text"/>	Agency NPI:	<input type="text"/>
Agency address:	<input type="text"/>	Agency phone #:	<input type="text"/>
City, State, ZIP:	<input type="text"/>	Agency fax #:	<input type="text"/>
Contact person at agency:	<input type="text"/>	Contact phone #:	<input type="text"/>

## Section B. Initial assessment request only

How many **hours** and **units** are you requesting for **CPT 97151 - assessment** (must meet Autism payment policy requirements) by the LABA  
Hours:  Units:

**Note: CPT 97151 is not reimbursed for behavior technicians**

Please attach a letter dated within the last 6 months and signed by a licensed physician or licensed psychologist that includes:

- an autism diagnosis, and
- a recommendation of ABA services.

## Section C. Service information

Does the agency named in Section A employ or reimburse behavior technician for ABA services?  Yes  No  
If no, please explain:

Has everyone who works with the member and their family completed a background check? (CORI/SORI)?  Yes  No  
If no, please explain:

If a behavior technician is employed, has he/she received specific ABA-related training?  Yes  No  
If yes, # of hours?

Member's diagnosis:

Patient name:	<input type="text"/>	Requested authorization start date:	<input type="text"/>
Member ID#:	<input type="text"/>	Date of birth:	<input type="text"/>

### Section C. Service information, *continued*

Indicate services the member receives from other providers, including Individualized Education Program (IEP) services.

Provider type	Hours/week	Does this provider collaborate with Licensed Applied Behavioral Analyst?	If no, please explain:
Occupational therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Speech therapist	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental health provider(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pediatrician/primary care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
How many hours per week is the member in school/pre-school/early intervention?			

Please provide information on number of ABA service hours per day and location of services.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Location H = home O = office C = community							
How many hours?							

Use the table below to indicate **hours** and **units per week** of services requested (must meet Autism payment policy requirements). **All units are in 15 minute increments.**

Code	Services rendered by a				Code	Services rendered by a			
	.....LABA		...behavior technician			....LABA		....behavior technician	
	Hours	Units	Hours	Units		Hours	Units	Hours	Units
0362T			not required		97154				
0373T			not required		97155			not reimbursed	
97151			not reimbursed		97156			not reimbursed	
97152					97157			not reimbursed	
97153					97158			not reimbursed	

### Section D. Treatment plan

Please attach an individualized, updated treatment plan (see Autism Services payment policy>Related Policies>[Treatment Plan Guidelines for Applied Behavior Analysis](#)). The plan should include:

- measurable goals,
- data related to progress within individual treatment goals,
- goal status (met, progressing, regressing), and
- plan for supervision.