Magellan HEALTHCARE®

superior healthplan™

Autism Benefit Services Request for Initial Evaluation

Please fax the following information to 888-656-0368, Attention: ABA support team.

The following items are a guide for submission:

MEMBER INFORMATION:

Member name:
Member's date of birth:
Medicaid ID#:
Member's phone number:
Language/cultural issues:

AGENCY/PROVIDER INFORMATION:

Agency name:
Phone number:
Mailing address:
Fax:
NPI/TIN #:
Agency contact name and phone number for clinical questions:
Case manager/LBA overseeing case
Provider In Network or Out of Network?

REQUESTED SERVICES (note: this form is for Initial Evaluation only. It is recommended that all requests for ongoing care be submitted with an updated treatment plan to 888-656-0368, Attention: ABA support team):

CPT code 97151, Number of hours:

REQUESTED START DATE OF SERVICE:

REASON FOR REFERRAL:

Identify the severe challenging behaviors that present a health or safety risk to self or others *or* significantly interfere with home or community activities.

- ☐ Health risk
- ☐ Self-injury
- ☐ Aggression toward others
- ☐ Destruction of property
- ☐ Stereotyped/repetitive behaviors
- ☐ Elopement
- ☐ Severe disruptive behavior
- ☐ Other, please specify

DATE AUTISM SPECTRUM DISORDER (ASD) DIAGNOSIS ESTABLISHED AND BY WHOM (Note: please attach any relevant documentation):

- Documentation of diagnosis within the last 3 years by a MD, Neurologist, PhD, PsyD or Licensed Psychologist.
- Diagnosis must meet DSM 5 criterion to diagnose ASD
- Validated assessment tools must be included i.e, ADOS, CARS

CLINICAL INFORMATION, as age and clinically appropriate:

REFERRAL FOR AUTISM BENEFIT SERVICES

Prescribing Provider's Name:
Phone Number:
Mailing address:
Fax:
Email:

ASSESSMENT TOOL USED FOR DIAGNOSIS AND FINDINGS

CURRENT DIAGNOSIS AND DATE OF INITIAL DIAGNOSIS

SPECIFY ASD DIAGNOSTIC CRITERION MET PER DSM-5 AND SEVERITY LEVEL

DEVELOPMENTAL EVALUATION COMPLETED

OT EVALUATION COMPLETED
SPEECH AND LANGUAGE EVALUATION COMPLETED

OTHER EVALUATION & DIAGNOSIS TESTS TO RULE OUT OTHER CONDITIONS COMPLETED(HEARING OF VISUAL ASSESSMENT IF APPLICABLE)

TRAUMA HISTORY

LIST MEDICATIONS (Include frequency and dosage)

MEDICAL ISSUES:

OTHER PHYSICAL FACTORS:
Date and results of last physical exam:
Date and results of last dental exam:
Date and results of last hearing exam:
Date and results of last vision exam:

PLEASE EXPLAIN COLLABORATION WITH SPECIAL SUPPORT SERVICES (Provided by the school district, regional center, or early childhood program):