LOUISIANA BLUE

Treatment for Applied Behavioral Analysis Request Form

This form is required when requesting authorization for Applied Behavioral Analysis (ABA) services for members diagnosed with Autism Spectrum Disorder. It must be submitted to Blue Cross and Blue Shield of Louisiana (Louisiana Blue) for both initial and concurrent reviews.

Complete all sections thoroughly. Include specific, individualized details about the member. Incomplete or vague responses may result in a peer review or denial of the request. Electronic submissions: Attach this completed form when submitting your request in iLinkBlue located at www.lablue.com/ilinkblue. Fax submissions: If you do not have iLinkBlue access, fax the form along with all supporting documentation to 1-800-363-9170. Need help? Contact our ABA Utilization Review Department at 1-800-821-2745.

MEMBER INFORMATION

Member's Name	Member ID Number
Date of Birth	Age
Location of Diagnosis (State)	Location of Treatment (State)
Diagnosing Provider	Diagnosis Date
Current Diagnosis Code(s)	
Is the Comprehensive Diagnostic Evaluation Attached? ☐ Yes ☐ No	

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name(s)	Contact Phone Number(s)
Parent/Guardian Email Address	
Note: If the member is 18 or older; guardianship paperwork is required to process request.	

PROVIDER INFORMATION

Contact Name	Contact Phone Number
Contact Email Address	
Provider Group Name	Provider Group Tax ID
Provider Group Address	
Behavior Analyst Name	Behavior Analyst NPI
Behavior Analyst Phone Number	Behavior Analyst Fax
Behavior Analyst Email Address	
Is the Behavior Analyst a participating Louisiana Blue provider? ☐ Yes ☐ No	

AUTHORIZATION INFORMATION

Requested Treatment Start Date

Requested Treatment End Date

Location(s) of Services (check all that apply)

☐ Clinic ☐ Home ☐ School ☐ Community ☐ Telehealth ☐ Other

CODE	HOURS REQUESTED	FREQUENCY
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
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		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization
		☐ Initial ☐ Weekly ☐ Monthly ☐ Per Authorization

TREATMENT PLAN

How many goals are new for the upcoming authorization period?

How many goals are being continued for the upcoming authorization period?

How many goals were mastered during the previous/current authorization period?

Describe observed gains and/or barriers impacting progress in the **communication domain**.

Describe observed gains and/or barriers impacting progress in the **social domain**.

Describe observed gains and/or barriers impacting progress in the **behavior domain**.

If any barriers were identified above, describe the steps currently being taken to address or resolve them.

ATTESTATIONS

☐ I attest that the treatment goals and clinical documentation are focused on active core deficits of ASD such as deficits in social communication, social interactions, and restrictive and repetitive patterns of behavior or interest.

☐ I attest that the treatment setting, and intensity (comprehensive vs. focused) is appropriate for the members' clinical needs with understanding that ABA treatment is not a substitute for academic, medical, or any other behavioral health services.

☐ I attest that the provider is accounting for skill generalization across multiple settings, meaningful caregiver involvement, coordinated care among all stakeholders, and active transition/discharge planning to appropriately fade services.

☐ I attest that all services are provided in a manner consistent with the Behavior Analysis Certification Board's Ethics Code for Behavior Analysts and any other relevant ethics code, generally accepted standards of care, and applicable state laws

Please list any additional relevant information here:

SUBMISSION CHECKLIST	
Did you include a complete comprehensive diagnostic evaluation, including an ASD-specific standardized assessment competed by a clinician who is licensed and qualified to make a diagnosis within the last 5 years? **This is required for an initial assessment.**	☐ Yes ☐ No
Did you include a referral signed by a licensed practitioner (e.g., MD, PSY.D, PhD) with a diagnosis of autism spectrum disorder recommending applied behavior analysis dated within the past year? **This is required for an initial assessment.**	☐ Yes ☐ No
Did you include a wellness check typically completed by a primary care physician (PCP) including a review of symptoms (ROS) with a neurological component dated within the past year? **This is required for an initial assessment.**	☐ Yes ☐ No
Did you include cognitive/developmental evaluation dated within the last 5 years? **If no, this will need to be submitted within the first 90 days of treatment.**	☐ Yes ☐ No
Did you include an adaptive Behavioral Evaluation dated within the past 6 months? **If no, this will need to be submitted within the first 90 days of treatment.**	☐ Yes ☐ No