ABA Service Checklist and Information Sheet

Member Information		
Name:	DOB:	Member ID/Plan:

Contacts for this request (preferably two contacts – insurance rep and/or LABA)	
Name:	Name:
Email:	Email:
Phone:	Phone:

Please select which service you are requesting today and make sure all components are submitted with your request.

Assessment ☐

- ☐ The Member is under the age of 21 years old.
- ☐ The Member has a definitive diagnosis of an autism spectrum disorder (DSM-5-TR) or Down Syndrome.
- ☐ The ASD diagnosis is made by a licensed Physician (i.e., PCP, etc.), Advanced Practice Registered Nurse, Physician's Assistant, or Psychologist experienced in the diagnosis and treatment of autism with developmental or child/adolescent expertise.
- ☐ The Down Syndrome diagnosis is made by a licensed Physician who is qualified to make such a diagnosis, and the diagnosis is confirmed by genetic testing.
- ☐ The diagnosis is accompanied by documentation of the evidence used to make the diagnosis.
- ☐ The diagnostic evaluation contains confirmation of medical screening and assessment to rule out other treatable causes and identify associated comorbidities as indicated.

Initial Services ☐

- ☐ Treatment plan (with baseline data for all goals) and request for units
- ☐ Behavior Intervention Plan (BIP, if any behaviors for reduction have been identified in the treatment plan)
- ☐ Treatment plan contains data from required assessment categories; skill, treatment impact/effectiveness, family/caregiver impact

If you did not previously request and receive authorization for assessment of this Member, please see assessment section and ensure information is included with request.

Concurrent Services (continued services) ☐

- ☐ Treatment plan (should always include initial baseline, current progress, and previous data as applicable)

Additional units for an active authorization ☐

- ☐ Clinical rationale with supporting data for your request
- ☐ Clear statement of units being requested and new total units for authorization

TPL (member has a different primary funder)

- ☐ TPL is covering services, and we are requesting a secondary authorization from MBHP for copays and deductibles.
  - ☐ Authorization letter or statement of authorized units and date of service needed. This must include Auth # or person spoken to at TPL insurer.
    - If ABA is not covered, please send that letter EVERYTIME.
    - If a member's primary does not require prior auth, please send documentation of that EVERYTIME.
  - ☐ Use Checklist above for what needs to be submitted based on your type of request.
- ☐ TPL has denied ABA coverage
  - ☐ Denial letter
  - ☐ Use checklist above for what needs to be submitted based on your type of request.

Service/Units Being Requested

Code	Dates of Service (DOS)	Number of Units
97151		
H0031		
97155		
97153		
97154		
97156		
97157		