Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Initial Request for ABA Therapy Form

This form is to be used by developmental pediatricians, other licensed physicians and psychologists who have experience or training in the diagnosis of Autism Spectrum Disorder. Individuals must have a diagnosis of Autism Spectrum Disorder or Stereotypic Movement Disorder and meet severity requirements, in order to receive prior authorization for ABA Therapy. Please provide the following information, by fax to (336) 499-4006, Attention: Utilization Management. Phone number for CBHA: (800) 475-7900

Member Name: _____
First Middle Last

Member's Address: _____
Street

_____
City State Zip

Member's Health Plan ID #: _____

Date of Birth: _____
Legal Guardian's Name: _____

Diagnosis: _____
Date of Diagnosis

Level of severity: _____
Other relevant medical or mental health diagnoses: _____
_____

_____
ASD Evaluating Clinician Credentials/Agency Phone

1) Is there a suspicion of a severe/profound intellectual developmental disability? __Yes __ No
2) Is the member legally blind and/or deaf? __Yes __No
3) Does the member display self-injurious behaviors? __ Yes __ No
4) Does the individual participate in one of the following: ___Early Intervention Services ___Pre-School ___School __Other __None
5) How much time does the member spend in one of these programs? (Mark N/A if none) __Full time __Part time __N/A

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6) There is a reasonable expectation on the part of the qualified evaluating healthcare professional that the individual's behavior will improve significantly with ABA therapy: __Yes __No (If no, please explain on a separate attachment)
7) Parents and Caregivers are committed to full participation in the ABA therapy program and training has been scheduled or will be scheduled: __Yes __No (if no, please explain in a separate attachment)
8) Does the member have an IEP? __ Yes __ No (If yes, please attach a copy of the IEP)
9) Please attach the evaluation of the individual. Note that the evaluation must have been completed within the past 2 years.

Requested amount of services:

Days per week: _____ Hours Per week ____

Location of service (i.e. clinic, home, etc) _____

I certify the accuracy and completeness of all information submitted on this form.

_____ _____
Name Date

P. O. Box 571137
Winston-Salem, NC 27157-1137
(336) 499-4000 (800) 475-7900