Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Evaluation (0359T) for ABA Therapy Form

This form is to be used by an evaluating autism provider to request authorization for a complete evaluation and treatment planning of Autism Spectrum Disorder. Individuals must have a diagnosis of Autism Spectrum Disorder (ASD) or Stereotypic Movement Disorder by a qualified provider. Please provide the following information, by fax to 1-888-908-7140, 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 Diagnosing 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) 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)

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

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