UHCCP TennCare/CoverKids ABA Treatment Request Form

Please fax this form to 1-877-217-6068 with your treatment plan

**please include your ABA assessment, confirmation of diagnosis and psychological evaluation, if available*

Member Name: _____ Member ID: _____

Member DOB: _____

Facility/Group Name: _____ Provider Tax ID #: _____

Provider Status: Choose one from list: _____ Fax #: _____

Facility/Group Address: _____

Supervisor's Name and Credentials: _____ Phone #: _____

Supervisor's Preferred Contact Days and Times: _____

Office Staff Contact Name: _____ Phone #: _____

Service Coordinator Name: _____ Phone #: _____

Please list all units/hours requested per week		
For Dates of Service After 10/1/2020 Note: all codes (except for T2002) are per 15 minutes		
97151	Behavior identification assessment, by professional	units/week
97152	Behavior identification supporting assessment, by one technician, under direction of professional (QHP may substitute for the technician)	units/week
0362T	Behavior identification supporting assessment, by technician, requiring: administration by professional on site, with assistance of two or more technicians, for patient w/destructive behavior, in customized environment	units/week
97153	Adaptive behavior treatment by protocol, by technician under direction of professional (QHP may substitute for the technician)	units/week
0373T	Adaptive behavior treatment with protocol modification, by technician, requiring: administration by professional on site, with assistance of two or more technicians, for patient w/destructive behavior, in customized environment	units/week
97154	Group adaptive behavior treatment by protocol, by technician under direction of professional (QHP may substitute for the technician)	units/week
97155	Adaptive behavior treatment with protocol modification, by professional	units/week
97156	Family adaptive behavior treatment guidance, by professional (with or without patient present)	units/week
97157	Multiple-family group adaptive behavior treatment guidance, by professional (without patient present)	units/week
97158	Group adaptive treatment with protocol modification, by professional	units/week

T2002	Transportation, per diem	units/week

Current Primary DSM-5 Diagnosis and Code Number: Click here to enter text.

Secondary DSM-5 Diagnosis and Code Number: Click here to enter text.

Who gave the diagnosis? Click here to enter text.

Date diagnosis was given: Click here to enter text.

Was a standard assessment used in the diagnosis of ASD, or an established supporting diagnosis for which ABA is proven to be an effective appropriate intervention or history of Traumatic Brain Injury: Choose an item.

Other Medical Conditions: Click here to enter text.

Medications: Click here to enter text.

Location of services: School, Home, Community/Group Home, Facility/Office? Choose an item.

Are there other UHCCP members in the home receiving ABA? Choose an item.

Hours per week of other therapeutic activities (speech therapy, occupational therapy, physical therapy, outpatient counseling, medication management, home-based services other than ABA, etc.): Click here to enter text.

Is there coordination of care with other providers? Note: If member is in other outpatient services then coordination of care is required and a list of all providers involved (name, address, phone, fax, and the next scheduled appointment) should be included in attached treatment plan. If no mental health providers are involved, list the local community mental health center name, address, phone, fax, and walk in hour times in the treatment plan. Choose an item.

- As appropriate and relevant, provider agrees to notify member's PCP/MH Providers (with member or guardian's consent) of current MH treatment, to coordinate treatment with health provider(s), and to arrange appropriate follow-up treatment for medical needs (during course of treatment and/or upon discharge).
- **TENNderCare (EPSDT) (Applicable to members under age 21)**
  UM informed provider that it is a contractual requirement to ensure that EPSDT screenings, immunizations, and services are current and, if not current, arranged for the member (with member or guardian consent).

Length of time member has been in ABA Services: Click here to entertext.

How long has the member been receiving this intensity of services: Click here to entertext.

Proposed Start Date of Authorization/Notification: Click here to entertext.

Proposed End Date of Authorization/Notification: Click here to entertext.

What is the severity of communication deficit? Choose an item.

What is the severity of social deficit? Choose an item.

What is the severity of behavior deficits? Choose an item.

What is the severity of destructive, maladaptive behaviors? Choose an item.

Describe the clinical interpretation of the response to treatment: Include functions of behavior, safety concerns, description of goals achieved within the authorization period, and barriers to treatment (culture, language, IQ, co-morbid diagnosis, caregiver support issues). Please refer to the Level of Care Guidelines for more information on concurrent request criteria if needed. Click here to entertext.

How many hours per month are the caregivers involved in either sessions or caregiver training? Choose an item.

How would you rate caregivers in regards to their proficiency with ABA techniques and working with the individual? Choose an item.

* Please note that an authorization is not a guarantee of payment; coverage is subject to all terms and conditions of the member's benefit plan. I hereby attest that all the information can be located in the member's medical record, and is true/accurate to the best of my knowledge:

Signature Required: