NEW AVENUES / MBHN: Request for ABA Treatment

Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624
Phone: (866) 925 - 5730 · Fax: (574) 271 – 5980

Facility/Company:	Rendering BCBA and Licensure:
Site Address:	Fax:
Phone:	Start Date of Requested Auth:
Provider Signature:	Date Signed:

Member Name:	DOB:
Parent/Primary Guardian Name:	Parent Phone:
Health Plan:	Member ID:
Diagnosis:	Diagnosing Provider:

Treatment Plan: **Observation Assessment** ☐**1st Review** ☐ **6 Month Review** **Start Date:**_____ **End Date:**_____

Program Duration: ❑ **Part-Time-20 hours** ❑ **Full-Time-40 hours** ❑ **Other**

Procedure Code	Procedure Description	# Units per Week	Place of Service
Initial ABA Identification Assessment - Limited to 8 hours Administered by Qualified Healthcare Professional			❑Facility ❑Home ❑School
0359T	BCBA: Behavior Identification Assessment (Untimed)		
0360T	BCBA: Observational Behavioral Follow-up Assessment 1st additional 30 minutes		
0361T	BCBA: Observational Behavioral Follow-up Assessment each additional 30 minutes		
	Total # of Units per week		
Clinical Supervision and Treatment Modification 1 Hour for every 10 hours of Direct Service			
0368T	BCBA: Adaptive Behavior Treatment and Protocol Modification 1st 30 minutes		
0369T	BCBA: Adaptive Behavior Treatment and Protocol Modification each additional 30 minutes		
0370T	Family Adaptive Behavioral Treatment Guidance		
0362T	Exposure Behavioral Follow-up Assessment 1st 30 minutes		
0363T	Exposure Behavioral Follow-up Assessment each additional 30 minutes		
	Total # of Units per week		
Direct Service ABA Treatment Administered by Technician			
0364T	Adaptive Behavior Treatment by protocol face-to-face with 1 patient 1st 30 minutes		
0365T	Adaptive Behavior Treatment by protocol face-to-face with 1 patient additional 30 minutes		
0366T	Group Adaptive Behavior Treatment face-to-face with 2 or more patients 1st 30 minutes		
0367T	Group Adaptive Behavior Treatment face-to-face with 2 or more patients each additional 30 minutes		
	Total # of Units per week		

IS PROVIDED DATA QUANTIFIABLE AND MEASURABLE?
THIS REQUEST WILL NOT BE PROCESSED IF DATA IS NOT QUANITIFIABLE/MEASURABLE.

The Services Listed Below Must Be Pre-Authorized Through The Medical Network		# of units per week	Place of Service ❑Facility ❑Home ❑School❑Other
97001/02	Physical Therapy (1hr unit)		
97003/04	Occupational Therapy (1hr unit)		
92506/07/08	Speech Therapy (1hr unit)		
	Other Therapy Services Weekly Total		

Summary paragraph of member's treatment/progress for last authorized treatment period:

1. Progress during last authorized treatment period:
   a. Number of Goals Improved: ☐
   b. Number of Goals Regressed: ☐
   c. Number of Goals w/ No Progress ☐
   d. Number of Goals On Hold ☐
   e. Number of Goals NYT ☐

2. Developmental Disability – Children's Global Assessment Scale Scores (See form following instruction letter):
   a. Self Care: ☐
   b. Communication: ☐
   c. Social Behavior: ☐
   d. School/Academic: ☐

3. Family Involvement with BCBA, A minimum of 50% of all parental involvement must be face-to-face.
   ❑Home-based - parent or guardian has been present at all times.
   ❑School-Based, Full-Time - parent or guardian has participated 1 hour per week.
   ❑School-Based, Full-Time - parent or guardian has participated 2 hours per week.
   ❑Facility-Based, Part-Time - parent or guardian has participated 1 hour per week.
   ❑Facility-Based, Full-Time - parent or guardian has participated 2 hours per week.

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4. Describe any medical/health co-existing conditions present? And are they being treated?

5. What medications are prescribed? Who is the prescribing physician?

6. Describe any cognitive/intellectual delays present?

7. Describe any social environmental barriers or stressors affecting progress?

8. Has attendance been steady as recommended? If not, please explain:

9. How is treatment addressing school transition or adaptation issues?

INFORMATION MUST BE TYPEWRITTEN, ADD ROWS AS NECESSARY TO LIST ALL GOALS.
REFER TO DIRECTION LETTER AS NECESSARY.

QUANTIFIABLE & MEASURABLE GOAL	TARGETING	QUANTIFIABLE & MEASURABLE BASELINE	PROGRESS AT DATE OF REQUEST
Example: Will hold eye contact, 90% of the time when being spoken to, over 3 consecutive days.	o *Not Yet Targeted* • *Targeting began 02/03/17*	*As of 02/03/17, holds eye contact 0% of the time.*	• *Improvement, during last treatment period: 25% over 3 days.* o *Regression, as evidenced by: ___________________* o *No Progress* o *On Hold as of:_________* o *Goal Met as of:________*
	o Not Yet Targeted o Targeting began _________________		o *Improvement, during last treatment period: ______________________* o *Regression, as evidenced by: ___________________* o *No Progress* o *On Hold as of:__________* o *Goal Met as of:_________*
	o Not Yet Targeted o Targeting began _________________		o *Improvement, during last treatment period: ______________________* o *Regression, as evidenced by: ___________________* o *No Progress* o *On Hold as of:__________* o *Goal Met as of:_________*
	o Not Yet Targeted o Targeting began _________________		o *Improvement, during last treatment period: ______________________* o *Regression, as evidenced by: ___________________* o *No Progress* o *On Hold as of:__________* o *Goal Met as of:_________*

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	o Not Yet Targeted o Targeting began ________________		o *Improvement, during last treatment period:* ____________________ o *Regression, as evidenced by:* __________________ o *No Progress* o *On Hold as of:*__________ o *Goal Met as of:*_________
	o Not Yet Targeted o Targeting began ________________		o *Improvement, during last treatment period:* ____________________ o *Regression, as evidenced by:* __________________ o *No Progress* o *On Hold as of:*__________ o *Goal Met as of:*_________
	o Not Yet Targeted o Targeting began ________________		o *Improvement, during last treatment period:* ____________________ o *Regression, as evidenced by:* __________________ o *No Progress* o *On Hold as of:*__________ o *Goal Met as of:*_________
	o Not Yet Targeted o Targeting began ________________		o *Improvement, during last treatment period:* ____________________ o *Regression, as evidenced by:* __________________ o *No Progress* o *On Hold as of:*__________ o *Goal Met as of:*_________
	o Not Yet Targeted o Targeting began ________________		o *Improvement, during last treatment period:* ____________________ o *Regression, as evidenced by:* __________________ o *No Progress* o *On Hold as of:*__________ o *Goal Met as of:*_________