VIVA HEALTH

Phone: 205-558-7475 Fax: 205-449-7049

Initial Assessment Request (0359T) for Applied Behavioral Analysis for Autism Spectrum Disorder

This form should be completed by the Board Certified Behavior Analyst (BCBA) or approved provider who will be rendering and/or supervising the services. Please complete all parts as clearly and as specifically as possible. Illegibility may result in a delay in the authorization. Omissions and generalities could result in a peer review or denial due to lack of information.

Identifying Data

Member's Name	Member's ID#
Date of Birth	Age
Current Diagnosis Code(s)	
Diagnosed by:	Diagnosis Date:
Has member had prior ABA treatment 2	
Previous Provider	Previous Treatment Dates

Education Information: *include grade, current and previous schools attended, dates and locations, special education or services provided*	
Does the member have an IEP? 1	If yes, please include a copy

Parent/Guardian Name(s)	Contact Number(s)
Parent/Guardian Email Address	

Provider Information

BCBA/AS Name		Provider NPI
Group Name		Group Tax ID Number
Address		
Phone	Fax	Email

201602

Authorization Information

Requested Assessment Date	Hours requested for 0359T
Has the BCBA/AS reviewed the following the diagnostic information? 2	
Has the BCBA/AS reviewed the previous treatment information? 2	
Has the BCBA/AS talked to the parent or guardian? 2	
Please list the assessments to be completed:	

All evidence-based screening and scaling results used in determining the diagnosis must be submitted with this request as required by individual state mandate. If the member has received Psychological or Neuropsychological Testing, Speech, Occupational, Physical or Psychiatric Therapy, please include summaries of those evaluations and treatments. Please refer to the Provider Manual for additional information regarding specific screenings and scales.

Each of the following should be submitted with the results of the completed assessment:

- History of current and past behavioral functioning
- Summary of previous assessments and health records
- Information from caregiver interview
- Standardized and non-standardized test and interpretation
- Completed treatment plan form
- Additional summary of information about member collected through observations, records review, etc., as appropriate

BCBA/AS Signature		Date
*Parent/Guardian Signature if required		Date
*MD/PhD Name	MD/PhD Phone	
*MD/PhD Signature if required - On Diagnostic		Date

**Benefits and requirements may vary by individual state mandates for these services. VIVA Health may ask for a copy of the signatures at any time.*