



Applied Behavior Analysis (ABA) Request

for Services Pursuant to Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

Request type: Extension

Date of Request:

Is Medicaid Primary?

Provider Name:	Provider ID w/ Service Loc:
BCBA Email Address:	Clinician Phone Number:
Name of BCBA:	Member ID:
Member Name:	Member Age and DOB:
Date of Comprehensive Assessment/ Provider:	Custodial Agency:
	Custody Status:

Estimated Duration of ABA Services (planned time from initiation of care to completion, in months)

Requested Start Date:	Requested End Date:	Hours Requested:
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Do you have a primary insurance provider? If so, please provide a copy of the primary insurer information. Does your primary insurance cover ABA? If so, to what extent (e.g. what is the maximum coverage for ABA services as to total hours, weeks, and/or total amount paid)? Have you been approved for ABA services? If so, for what amount and frequency?

List the guardian's name and relationship to member including their address and phone number. If DHS/OJA involvement, list caseworker contact info including email address.

Please document the date(s) of when the member & family/caregiver were able to apply ABA technique(s) consistently and appropriately within this review period.

Describe how the ABA treatment specifically improved the member's atypical or disruptive behaviors over the last 30 days (e.g. improvements in: impulsive aggression towards self and others, self injury, intentional property destruction, etc?)

Describe the member's specific improvements due to ABA treatment of the disruptive behaviors over the last 14 days, including the specific date(s) and time(s). (e.g. what led up to the incidents, what interventions were attempted & were they successful or did they fail, how long did the member's episode of disruptive behaviors last, and did the member sustain injuries to self, others, or property?)

DSM-5 diagnoses with accompanying specifiers (e.g., 299.00 Autism Spectrum Disorder). The primary diagnosis must be ASD related.

Diagnoses:

Primary
Diagnosis Code:

Diagnosis
Description:

Diagnosis
Code:

Diagnosis
Description:

DESCRIBE HOW TREATMENT IS BEING COORDINATED WITH OTHER PROVIDERS INVOLVED IN MEMBER'S CARE

Provider Type <small>(include Provider Name and Phone Number in the boxes)</small>	Part of member's treatment team?	Date Last Contacted	Description of Care Coordination
Primary Care Physician/ Psychiatrist			
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Behavioral Health Therapist			

Provider Type (include Provider Name and Phone Number in the boxes)	Part of member's treatment team?	Date Last Contacted	Description of Care Coordination
School Based Services			
Other Services			

BEHAVIORS TARGETED FOR REDUCTIONS

Date Behavior was Identified	Behavior (e.g., bolting from caregiver, aggression, etc) Please be specific.	Please describe where services were provided within this 30 day period? (i.e. home, office, etc.)	Target Date for Completion

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