AmeriHealth Caritas
District of Columbia

Autism Spectrum Disorder (ASD) Treatment Request Form

Please print clearly — incomplete or illegible forms will delay processing. Please fax to: AmeriHealth Caritas District of Columbia's Behavioral Health Utilization Management (BHUM) department at **1-855-410-6638**. For assistance contact: **1-877-464-2911**.

Member information		
Patient name:	Legal guardian:	Member date of birth:
Medicaid/Health plan #:	Last authorization # (if applicable):	

Provider information (board-certified behavior analyst [BCBA]/licensed provider)		
Group/agency name:	☐ In network ☐ Out of network ☐ In credentialing process	
Provider name:	Provider credential: ☐ MD ☐ PhD ☐ LIP ☐ BCBA ☐ BCaBA ☐ RBT II ☐ RBT I	
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Physical address:	Phone number:	Fax number:
Medicaid/Provider/NPI #:	Contact name:	

Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis		
Primary DX:	Secondary DX:	Medical DX:
Is the member diagnosed with an ASD?		

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to AmeriHealth Caritas DC's BHUM department for a medical necessity determination. A failure to submit all clinical documentation may delay processing this request.

1. Diagnostic evaluation/report (initial requests).
2. Full behavior support plan/treatment plan (including symptoms/behaviors requiring treatment, specific treatment interventions, and that these were indicated by the assessment tool).
3. ABA therapy progress summary, including cumulative graphs of progress/standard celeration charts.
4. Sample schedule of treatment.
5. Documentation of caregiver goals, involvement in treatment, and progress in skill development.

Additional information: _____

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List of any other services the member is receiving, including service names/therapy, number of hours per week of each and the targets of those treatments, and evidence of coordination with school, preschool, or early intervention program and other therapy providers (coordination that is more than a phone call or notification of enrollment).

School/preschool/early intervention program:

Type of service	Number of hours/week	Behaviors/deficits targeted

Other therapies provided:

Type of service	Number of hours/week	Behaviors/deficits targeted

Summary of contact with other providers:

Treatment request:

Treatment start date:

ASD treatment	Units	CPT code	Time frame (weekly/monthly)
Behavior identification assessment (ABA)		97151	
Adaptive behavior treatment with protocol modification		97155	
Adaptive behavior treatment by protocol		97153	
Family adaptive behavior treatment guidance		97156	
Therapeutic behavioral service		H2019	
Behavior identification- supporting assessment		97152	
Exposure behavioral follow-up assessment		0362T	
Group adaptive behavior treatment by protocol		97154	
Multiple family group adaptive behavior treatment		97157	
Group adaptive behavior treatment with protocol modification		97158	
Adaptive behavior treatment with protocol modification		0373T	

Provider signature with credentials and date:

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.