Healthy Blue

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Medicaid Managed Care

Member's Name:	Medicaid ID Number:

ABA REQUEST FOR THERAPY

Parent/Guardian:	**Patient's Primary Phone Number:**
Date of Birth:	**Age of Patient:**
SSN:	**Grade Level:**
Name of Evaluator:	**Name of Clinic/Phone Number:**
Credentials:	
Date(s) of Evaluation:	**Length of Time Evaluator Spent With Child:**

PSYCHOSOCIAL HISTORY

History of the Child

Provide relevant history of the child including how long you have seen the child and notes on home and education life.

Behaviors Reported

Description of Behavior	Reporter Name	Environment Where Behavior Occurs	Frequency of Behavior	Severity of Behavior

Clinical Observations

Describe observations while the child was in the clinic. (Note current functioning in social behavior and communication, play or peer interaction)

Current Medical and/or Behavioral Diagnoses

Description (Attach records reviewed as part of the diagnostic evaluation or your diagnostic report).	ICD-10 code	Treatments

Medications

List all medication patient is taking.	Current	Past	Reason for Prescription

Screening/Assessment Instruments Used

Name of Tool	Result	Scores

Recommendations for any additional treatment, care or services, specialty medical or behavioral referrals, specialty consultations, and/or any additional recommended standardized measures, labs or other diagnostic evaluations considered clinically appropriate and/or medically necessary.

I certify that I am the clinician for this pediatric patient. Based on information provided below, in my professional opinion ABA Services are medically necessary and appropriate for the recipient's condition.

Signature **Date**

BLAPEC-1054-18 October 2018