



Fax Form to: 1-866-582-2287



Behavior Therapies such as Applied Behavior Analysis Adaptive Behavior Assessment Request Form

Patient Information:

Patient's Name: _____

Patient's DOB: _____

Subscriber ID #: _____

Diagnostic info:

Diagnosis: _____

Subtype: _____

Specifier: _____

Provider Information:

Psychosocial Context: _____

Name of Provider (Include Licensure/Certification)

Diagnosed by whom: _____

Federal Tax ID#/ NPI #

Diagnosed date: _____

Street Address City State Zip

Please attach diagnostic assessment report if available.

Telephone # Email Address Fax #

Referral for ABA services made by?

- Family Advocacy Group
- Provider _____
- Other _____

Assessment, Treatment Information and Recommendations:
(Completed by BCBA/BCaBA/licensed provider according to state mandate)

Has an Intake Session Taken Place? ___ Yes ___ No (Attach notes if intake has taken place)

Date of Intake Session: _____

Reason for referral and purpose of assessment/testing:

Assessments Tool being used (i.e., ABBLs, VB-MAPP, FBA, etc.) _____

**ANTHEM BLUE CROSS AND BLUE SHIELD BEHAVIORAL HEALTH
AUTISM SPECTRUM DISORDERS**



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(Continued)

Assessment Type	Units	CPT code	Mark the box next to assessment being requested
Behavior Identification Assessment	1	0359T	<input type="checkbox"/>
Observational Behavioral Follow-Up Assessment		0360T	<input type="checkbox"/>
- Each additional 30 minutes of technician time		0361T	<input type="checkbox"/>
Exposure Behavioral Follow-up Assessment		0362T	<input type="checkbox"/>
- Each additional 30 minutes of technician(s) time		0363T	<input type="checkbox"/>

The typical authorization does not exceed 8 hours for an assessment. If you are requesting additional units, please submit documentation to support the medical necessity for the additional hours.

Provider Signature _____ Date _____

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