ANTHEM BLUE CROSS AND BLUE SHIELD BEHAVIORAL HEALTH
AUTISM SPECTRUM DISORDERS

Anthem

Fax Form to: 1-866-582-2287

Anthem
UM Services, Inc.

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

Patient Information:

Patient's Name: _____

Patient's DOB: _____

Subscriber ID #:_____

Provider Information:

_____
Name of Provider (Include Licensure/Certification)

_____
Federal Tax ID#/ NPI #

_____
Street Address City State Zip

_____
Telephone # Email Address Fax #

Diagnostic info:

Diagnosis: _____

Subtype: _____

Specifier: _____

Psychosocial Context:_____

Diagnosed by whom: _____

Diagnosed date: _____

Please attach diagnostic assessment report if available.

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

Anthem

Fax Form to: 1-866-582-2287

Anthem
UM Services, Inc.

(Continued)

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

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 _____