ANTHEM BLUE CROSS AND BLUE SHIELD TREATMENT PLAN REQUEST FORM FOR AUTISM SPECTRUM DISORDERS

Anthem BlueCross BlueShield

Fax Treatment Plans to: 1-866-582-2287

Anthem UM Services, Inc.

Demographics	Physician
Member's Name_____ Member's ID #_____ Date of Birth: _____ Age _____ Gender: M F Reference # _____ (Concurrent review only)	Provider's Name_____ Provider's Tax ID #_____ Address: _____ Phone: _____ Fax:_____
Diagnostic Information	**BCBA/Licensed Provider**
Diagnosis: _____ Subtype: _____ Specifier: _____ Psychosocial Context: _____ Other Relevant History/Symptoms: _____ Diagnosed by whom:_____ Diagnosed date: _____	**Name**:_____ Tax ID/NPI Number:_____ Address:_____ Phone:_____ Fax:_____ **Name**:_____ Tax ID/NPI Number:_____ Address:_____ Phone:_____ Fax:_____

Assessment and Treatment

Standardized Assessment Tool used: _____

In addition to the information on this form, please attach:

- Full Behavior Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
  - Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms.
- Diagnostic evaluation/report (initial request only)
- List any other services the member is receiving (i.e PT/OT/ST/school)
- Coordination of care with other providers.
- Cumulative graphs of progress/standard celeration charts
- A sample schedule of treatment
- Documentation of parental involvement, parent goals

Information older than 30 days will not be accepted for concurrent review

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Authorization Request **Start Date of Treatment Plan:** _____

Adaptive Behavior Treatment	**Units**	**CPT code**	**Timeframe (weekly/monthly)**
Adaptive Behavior Treatment by Protocol (first 30 minute)		0364T	
- Each additional 30 minutes of technician time		0365T	
Group Adaptive Behavior Treatment by Protocol (first 30 minute)		0366T	
- Each additional 30 minutes of technician time		0367T	
Adaptive Behavior Treatment w/ Protocol Modification (first 30 minute)		0368T	
- Each additional 30 minutes of patient face-to-face time		0369T	
Family Adaptive Behavior Treatment Guidance		0370T	
Multiple-Family Group Adaptive Behavior Treatment Guidance		0371T	
Adaptive Behavior Treatment Social Skills Group		0372T	
Exposure Adaptive Behavior Treatment with Protocol Modification (first 60 minutes)		0373T	
- Each additional 30 minutes of technician(s) time face-to-face with patient		0374T	

Provider Signature_____ License Information_____ Date_____

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

Physician/Psychologist Printed

Name_____

Physician/Psychologist Signature_____ License Information _____Date_____

My signature confirms that I am participating in coordination of care for this treatment plan.