Wellmark BlueCross BlueShield Federal Employee Program

SAVE

Applied Behavior Analysis for the Treatment of Autism (Pre-Service Inquiry)

Patient Name (Last, First, Middle Initial): _____

Patient's Date of Birth: _____/_____/_____ ☐ Male ☐ Female

Relationship to the Certificate Holder: ☐ Self ☐ Spouse ☐ Dependent

Certificate Holder Name (Last, First, Middle Initial): _____

Certificate Holder Identification Number: _____

Certificate Holder Address: _____

City: _____ State: _____ Zip: _____

Provider Name: _____ Provider NPI#: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Provider Phone Number: (_____) _____ - _____ Provider Fax Number: (_____) _____ - _____

Services to be Approved

Anticipated Date of Service	CPT/HCPC Codes - List Each Code Separately (Mandatory)	Total Number of Units per code and also designate the following (Mandatory): D = per day W = per week M = per month	Description of Service

ABA Services are subject to prior approval, however, prior approval does not guarantee coverage.

NOTE: If this request is for **Initial Prior Approval Request**, go to number 1.
If this request is for **Ongoing Prior Approval Request**, go directly to number 2.
If this request is for a **New Problem or New Symptoms and Adjustments to Treatment Plan**, go directly to number 3.

1. Initial Prior Approval Request:

The individual has an established diagnosis of Autism Spectrum Disorder (ASD):

☐ Yes
☐ No

Provide diagnosis code(s): _____

There is no suspicion of severe/profound intellectual disability:

☐ Yes
☐ No

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

Individual is legally blind and/or deaf:

☐ Yes, please specify: _____ (if yes, this will require secondary medical review)
☐ No

Less intensive behavior treatment(s) or therapy has been considered or applied and has not been sufficient in the following:

☐ Reducing the interfering behavior(s)
☐ Increase positive social skills
☐ Maintain desired behaviors
☐ Less intensive behavior treatment(s) or therapy has not been considered or applied

The ABA therapy will be rendered face to face and on a 1:1 basis with the patient:

☐ Yes
☐ No, please explain: _____

There is a reasonable expectation on the part of the qualified treating health care professional who has completed an initial evaluation of the individual that the individual's behavior will improve significantly with ABA Therapy:

☐ Yes
☐ No, please explain: _____

Does the individual attend and participate in one of the following:

Early intervention service program, preschool or school (specify which one): _____

☐ Full time
☐ Part time
☐ Not enrolled (explain): _____
☐ Not able to attend (explain):_____

Full assessment is planned to include the development of an individualized treatment plan which will be completed within the first 90 days of therapy and will be submitted with the next review request:

☐ Yes
☐ No, please explain: _____

Parent(s) and Caregiver(s) are available and committed to full participation in the ABA therapy program and training has been scheduled or will be scheduled:

☐ Yes
☐ No, please explain: _____

Total number of days per week and hours per day of direct services to the patient, parent(s) or caregiver(s) to include duration and location of the requested ABA Therapy:

Days per week: _____ Number of hours per day: _____ Location of services: _____

Provide licensure, certification and credentials of the professional(s) providing services to the individual through the ABA therapy program:

_____

2. Ongoing Prior Approval Request:

The ABA Therapy will be rendered face to face and on a 1:1 basis with the patient:

☐ Yes
☐ No, please explain: _____

The ABA Therapy is not making the symptoms/behaviors persistently worse:

☐ Yes
☐ No

There continues to be reasonable expectation on the part of the qualified treating health care professional(s) that the individual's behavior will continue to improve significantly with the ABA therapy:

☐ Yes
☐ No, please explain: _____

Does the individual attend and participate in one of the following:

Early intervention service program, preschool or school (specify which one): _____

☐ Full time
☐ Part time
☐ Not enrolled (explain): _____
☐ Not able to attend (explain):_____

The individual treatment plan and/or therapy progress report has been completed, updated and progress toward goals has been identified:

☐ Yes (attach treatment plan and progress report documents and any additional medical necessity documentation)
☐ No, please explain: _____

Parent(s) and/or caregiver(s) remain engaged in the treatment plan, following all appropriate treatment recommendations (e.g. individual and or family therapy, pharmacological therapy and techniques learned in ABA therapy):

☐ Yes

☐ No, please explain: _____

Total number of days per week and hours per day of direct services to the patient, parent(s) or caregiver(s) to include duration and location of the requested ABA Therapy:

Days per week: _____ Number of hours per day: _____ Location of services: _____

Provide licensure, certification and credentials of the professional(s) providing services to the individual through the ABA therapy program:

_____

Please provide additional information: (Attach Medical Necessity documentation to include treatment plan and progress report documents and any other necessary information.)

_____

_____

I certify the accuracy and completeness of all information reported by me on this form.

Provider Signature: _____ **Date:** _____/_____/_____

Provider: Please complete this form and submit to Wellmark to the fax number given below:

Wellmark Blue Cross and Blue Shield of Iowa: 515-376-9104 — Prior Approval Unit — Mail Station 5W198