UHCCP TennCare/CoverKids ABA Initial Assessment Request Form

Please fax this form to 1-877-217-6068

**please include confirmation of diagnosis and psychological evaluation, if available*

Member Name: _____ Member ID: _____

Member DOB: _____

Facility/Group Name: _____ Provider Tax ID #: _____

Provider Status: Choose one from list: _____ Fax #: _____

Facility/Group Address: _____

Supervisor's Name and Credentials: _____ Phone #: _____

Supervisor's Preferred Contact Days and Times: _____

Office Staff Contact Name: _____ Phone #: _____

Service Coordinator Name: _____ Phone #: _____

Please list all units/hours requested per week		
For Dates of Service After 10/1/2020 Note: all codes (except for T2002) are per 15 minutes		
97151	Behavior identification assessment, by professional	units/week
97152	Behavior identification supporting assessment, by one technician, under direction of professional (QHP may substitute for the technician)	units/week
0362T	Behavior identification supporting assessment, by technician, requiring: administration by professional on site, with assistance of two or more technicians, for patient w/destructive behavior, in customized environment	units/week
T2002 (1 unit per Roundtrip)	Transportation for distances over 30 miles one way from provider base address.	units/week

Assessment Start Date Requested Assessment End Date Requested

Current Primary DSM-5 Diagnosis and Code Number: Click here to enter text.

Secondary DSM-5 Diagnosis and Code Number: Click here to enter text.

Who gave the diagnosis? Click here to enter text.

Date diagnosis was given: Click here to enter text.

Was a standard assessment used in the diagnosis of ASD, or an established supporting diagnosis for which ABA is proven to be an effective appropriate intervention or history of Traumatic Brain Injury: Choose an item.

Other Medical Conditions: Click here to enter text.

Medications: Click here to enter text.

Describe why ABA is medically necessary: (include skill deficits, communication deficits, and behavior concerns) Click here to enter text.

If the member has had previous ABA services, please include the following (Dates of service, Provider Name, Length of Treatment, and Response to Treatment) Click here to enter text.

List all less intensive services that have been previously tried or are currently being utilized (such as: Behavioral Health Intensive Community Based Treatment, CCFT, psychiatric services, school based services, outpatient therapy, or rehab services (vocational, speech, OT, PT): Click here to enter text.

If the member is in any additional services how will coordination of care be achieved? Treatment coordination: Per the Provider Manual, the expectation is that the treating provider will make efforts to obtain ROI(s) and to inform other behavioral health providers (mental health and/or substance abuse) of the member's admission, treatment and discharge and to coordinate with the(se) providers. If no mental health providers are involved, list the local community mental health center name, address, phone, fax, and walk in hour times available. Click here to enter text.

- As appropriate and relevant, provider agrees to notify member's PCP/MH Providers (with member or guardian's consent) of current MH treatment, to coordinate treatment with health provider(s), and to arrange appropriate follow-up treatment for medical needs (during course of treatment and/or upon discharge).
- **TENNderCare (EPSDT) (Applicable to members under age 21)**
  UM informed provider that it is a contractual requirement to ensure that EPSDT screenings, immunizations, and services are current and, if not current, arranged for the member (with member or guardian consent).

* Please note that an authorization is not a guarantee of payment; coverage is subject to all terms and conditions of the member's benefit plan. I hereby attest that all the information can be located in the member's medical record, and is true/accurate to the best of my knowledge:

Signature Required: