Behavioral Health Treatment – Applied Behavioral Analysis Recommendation Form

Please submit the completed form with requested documentation via fax to L.A. Care BH ASD Program Department: Fax: 1.213.438.5054. If the provider would like to discuss the request, please call 1.888.347.2264 or 1.213.438.5631.

Requesting Provider Information

Date of Referral: (mm/dd/yyyy)

Requested Date of Service: (mm/dd/yyyy)

Referring Individual Name:

Referring Organization Name:

Phone Number:

Fax Number:

Address:

Regional Center, if applicable:

LEA (Local Education Agency):

Servicing Provider Information (if different from requesting source)

Referring Individual Name:

Referring Organization Name:

Phone Number:

Fax Number:

Address:

Patient Information

First Name:

Last Name:

Medi-Cal Client ID# (CIN):*

Date of Birth: (mm/dd/yyyy)

Caregiver Information:

Preferred Language:

Mailing Address or Location:

Primary Phone Number:

Best Time to Contact:*

DSM-V/ICD-10 Code(s)/Description: ☐ 299.00 ☐ F84.0 ☐ Other: _____

L.A. Care HEALTH PLAN®

Behavioral Health Treatment – Applied Behavioral Analysis Recommendation Form

Service Type Requested

☐ **Comprehensive Diagnostic Evaluation (CDE)** — evaluation for ABA recommendation

All 4 criteria must be met:

1. Is the member under 21 years old: ☐ Yes ☐ No
2. Initial psychological evaluation does not require ABA recommendation
3. Is medically stable with documentation attached (e.g., licensed physician note indicating general health): ☐ Yes ☐ No
4. Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/DD): ☐ Does have a need ☐ Does not have a need
   Hours requested: _____

☐ **Functional Behavioral Assessment (FBA)** — initial services

All 4 criteria must be met:

1. Is the member under 21 years old: ☐ Yes ☐ No
2. Has a recommendation from a licensed physician, surgeon, or psychologist that evidence-based BHT services are medically necessary with documentation attached: ☐ Yes ☐ No
3. Is medically stable with documentation attached (e.g., licensed physician note indicating general health): ☐ Yes ☐ No
4. Does not have a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/DD): ☐ Does have a need ☐ Does not have a need

Requested services and hours:

☐ H0032-HP (required): Functional Behavioral Assessment — Hours requested: _____
☐ H0032-HC: Functional Behavioral Assessment — Hours requested: _____
☐ H0032-HN (supporting documents needed: transcript, attestation) — Hours requested: _____

☐ **Continuity of Care (COC)** — continued ABA services

<u>Must provide reports/supporting documents</u>

☐ H2019-HN, HH, HC, HP Direct Services — Hours requested: _____

Parent Education Training

☐ S5111-HP (required) — Hours requested: _____
☐ S5111-HC — Hours requested: _____
☐ S5111-HN (supporting documents needed: transcript, attestation) — Hours requested: _____

Case supervision direct or indirect

☐ H0031-HP (required) — Hours requested: _____
☐ H0031-HC — Hours requested: _____
☐ H0031-HN (supporting documents needed: transcript, attestation) — Hours requested: _____

Clinical indication for request/additional information:

Provider Name and Credentials: _____ Provider Signature: _____

Provider Agency: _____ Date: _____

AUTHORIZATION IS CONTINGENT UPON MEMBER'S ELIGIBILITY ON DATE OF SERVICE
Do not schedule services until authorization is obtained.