Applied Behavior Analysis
Request to Perform Evaluation and Treatment Planning

This form should be completed by the Board Certified Behavior Analyst (BCBA) who will be rendering and/or supervising the services Please complete all parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification.

Date of Initial Request:

Member Name:	Member ID #:	**DOB:**
		Age:

Name of BCBA professional who will perform/supervise service:		
Provider NPI#:	**Is the Provider:** ☐ **Contracted** ☐ **Non-Contracted with PHP**	
Tax ID:	**Phone #:**	**FAX #:**
Mailing Address:		
City:	**State:**	**Zip:**
Name of person at provider's office to notify with the Authorization decision (and phone # if different than above)	**Who referred patient to you?**	

Clinical Information:
Has a comprehensive diagnostic evaluation by a physician been completed? (If so, please attach a copy to this form.) ☐ **Yes** ☐ **No**
If yes, by whom? _____ **Date evaluation complete:** _____

What is the member's definitive diagnosis:
_____

Is the patient receiving Early Intervention Services (if applicable)?	☐ **Yes**	☐ **No**	☐ **Not applicable**
Will the parent/legal guardian be present at all treatment visits?	☐ **Yes**	☐ **No**	
Has the patient been evaluated by a school?	☐ **Yes**	☐ **No**	
Is the patient receiving services from a school?	☐ **Yes**	☐ **No**	
Hrs. per day/wk. _____	☐ **Yes**	☐ **No**	

What is the date span for the assessment? _____

**Providers of the services must supply codes associated with the assessment

Code	Description	Frequency	Units

Request to Perform Behavior Health Analyst Assessment & Treatment Planning

_____ _____
Signature of Certified Behavior Health Analyst **Date**

FAX OR EMAIL COMPLETED FORM TO:
Vālenz Health at (260) 918-8219 or Carecustomerservice@Valenzhealth.com