# 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:**

**PHP at (260) 436-4809 or medmanfax@phpni.com**