59986

MHNet BEHAVIORAL HEALTH

Autism/Applied Behavior Analysis Services

Member Name **(Please Print):**

Provider Name & License/Certification Type **(Please Print):**

Member ID #:

NPI:

Tax ID #:

DOB: / /

Check box if member has been previously hospitalized. ☐

Diagnoses

Axis I: . Axis II: . GAF:

Axis I: . Axis III: . Axis IV:

List Medications Below:

CPT/HCPCS Codes Requested**

	Numeric Code	*Modifier*	*# Units*
CPT:			
CPT:			
CPT:			
CPT:			

Provider Signature:

Date Signed: / /

****TO ENSURE PAYMENT**, only request the contracted codes found on your fee schedule.****

Treatment Plan Attached ☐

FUNCTIONAL IMPAIRMENT RATING SCALE Fill in the bubble like this ● to indicate current level of impairment in each domain.	**CURRENT LEVEL OF IMPAIRMENT** None		Moderate		Severe
Safety/Behavioral Risks Aggression, self-injurious behavior, property destruction	○	○	○	○	○
Communications Deficits Problems with expressive or receptive language, poor understanding or use of non verbal communications, stereotyped or repetitive language	○	○	○	○	○
Impaired Social Interactions Lack of social/emotional reciprocity, failure to seek or develop shared social activities	○	○	○	○	○
Autistic Behavior Patterns Self-stimulating through repetitive/stereotyped motions; abnormal, inflexible, or intense preoccupations	○	○	○	○	○
Self-care Skills Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills	○	○	○	○	○
Other Medical Conditions Presence of medical conditions which have significant impact on patient functioning and/or quality of life	○	○	○	○	○

PROGRESS TOWARDS GOALS SINCE LAST REVIEW Fill in the bubble like this ● to indicate degree of progress in each domain.	Regressed	Unchanged	Improved	Goal Completed
Safety/Behavioral Risks	○	○	○	○
Communications Deficits	○	○	○	○
Impaired Social Interactions	○	○	○	○
Autistic Behavior Patterns	○	○	○	○
Self-care Skills	○	○	○	○

PLEASE SUBMIT A COPY OF THE MOST CURRENT TREATMENT PLAN WITH THIS REQUEST.
(Updated treatment plans are required every 6 months.)

Member Name and **Member ID #** must appear on every page of the treatment plan.

Fax Completed Forms To: 877-675-7421

Provider Secure Fax # **(Required)**

State: **(Required)**