ANTHEM BLUE CROSS TREATMENT PLAN REQUEST FORM
AUTISM SPECTRUM DISORDERS

Fax Treatment Plans to: 1-866-582-2287

Anthem BlueCross

Anthem UM Services, Inc.

Demographics

Member's Name _____

Member's ID # _____

Date of Birth _____ **Age** _____ **Gender:** M F

Reference # _____
(Concurrent review only)

Physician

Provider's Name _____

Provider's Tax ID # _____

Address _____

Phone _____ **Fax** _____

Diagnostic Information

Diagnosis _____

Subtype _____

Specifier _____

Psychosocial Context _____

Other Relevant History/Symptoms _____

_____

Diagnosed by Whom _____

Diagnosed Date _____

BCBA/Licensed Provider

Name _____

Tax ID/NPI Number _____

Address _____

Phone _____ **Fax** _____

Name _____

Tax ID/NPI Number _____

Address _____

Phone _____ **Fax** _____

Assessment and Treatment

Standardized Assessment Tool used _____

In addition to the information on this form, please attach:

- Full Behavior Support Plan/Treatment Plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
  Describe desired outcomes/alleviation of problems and/or symptoms in specific, behavioral and measurable terms.
- Diagnostic evaluation/report (initial request only)
- Coordination of care with other providers
- Cumulative graphs of progress/standard celeration charts
- Documentation of parental involvement, parent goals
- List any other services the member is receiving (i.e. PT/OT/ST/school)
- A sample schedule of treatment
- Information older than 30 days will not be accepted for concurrent review

Authorization Request

Start Date of Treatment Plan: _____

Adaptive Behavior Treatment	Units	CPT code	Timeframe (weekly/monthly)
Adaptive Behavior Treatment by Protocol **(first 30 minute)**		0364T	
- Each additional 30 minutes of technician time		0365T	
Group Adaptive Behavior Treatment by Protocol **(first 30 minute)**		0366T	
- Each additional 30 minutes of technician time		0367T	
Adaptive Behavior Treatment w/ Protocol Modification **(first 30 minute)**		0368T	
- Each additional 30 minutes of patient face-to-face time		0369T	
Family Adaptive Behavior Treatment Guidance		0370T	
Multiple-Family Group Adaptive Behavior Treatment Guidance		0371T	
Adaptive Behavior Treatment Social Skills Group		0372T	
Exposure Adaptive Behavior Treatment with Protocol Modification **(first 60 minutes)**		0373T	
- Each additional 30 minutes of technician(s) time face-to-face with patient		0374T	

Provider Signature_____ **License Information**_____ **Date**_____

My signature confirms that any paraprofessional under my supervision has the appropriate education and training.

Physician/Psychologist Printed Name_____

Physician/Psychologist Signature_____ **License Information**_____ **Date**_____

My signature confirms that I am participating in coordination of care for this treatment plan.