

**ANTHEM BLUE CROSS AND BLUE SHIELD TREATMENT PLAN REQUEST FORM FOR  
AUTISM SPECTRUM DISORDERS**



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



Demographics	Physician
Member's Name _____	Provider's Name _____
Member's ID # _____	Provider's Tax ID # _____
Date of Birth: _____ Age _____ Gender: M F	Address: _____
Reference # _____	Phone: _____
(Concurrent review only)	Fax: _____

Diagnostic Information	BCBA/Licensed Provider
Diagnosis: _____	<b>Name:</b> _____
Subtype: _____	Tax ID/NPI Number: _____
Specifier: _____	Address: _____
Psychosocial Context: _____	Phone: _____ Fax: _____
Other Relevant History/Symptoms: _____	<b>Name:</b> _____
Diagnosed by whom: _____	Tax ID/NPI Number: _____
Diagnosed date: _____	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)
- List any other services the member is receiving (i.e PT/OT/ST/school)
- Coordination of care with other providers.
- Cumulative graphs of progress/standard celeration charts
- A sample schedule of treatment
- Documentation of parental involvement, parent goals

Information older than 30 days will not be accepted for concurrent review

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Authorization Request

Start Date of Treatment Plan: \_\_\_\_\_

<b>Adaptive Behavior Treatment</b>	<b>Units</b>	<b>CPT code</b>	<b>Timeframe (weekly/monthly)</b>
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.*

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