Penn Medicine
Penn Behavioral Health Corporate Services

Autism Spectrum Disorder
Initial Assessment Authorization Request Form

PROVIDERS: COMPLETE TO REQUEST AUTHORIZATION BEFORE RENDERING TREATMENT AND BEFORE COMPLETING INITIAL TREATMENT PLAN

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. All services require preauthorization

Patient Identification

Patient Name _____ DOB _____ Age _____

Address _____ City _____ State ____ Zip _____

Guardian _____ Relationship to patient _____ Phone _____

Provider Information

Name and credentials of provider completing Comprehensive bio-psychosocial evaluation

_____

Group _____ Contact _____

Address _____ City _____ State ____ Zip _____

Phone # _____ Fax # _____

H0031 - Total Hours Requested _____ **Scheduled Date of Service** _____

For Internal Use only

PBHCS Received on _____ by _____ eCura ID# _____

H0031 - Total Hours approved _____ PBHCS Authorization Sent on _____

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