Autism Treatment Request Form

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.
Send completed forms to Quest Behavioral Health by fax to 717-851-1414.

☐ **Initial Treatment Plan – Providers complete this entire form before beginning treatment with a new patient.**

☐ **Updated Treatment Plan – Complete Parts 1, 3,4, & 5. Complete Part 2 only when Bio-psychosocial information changes.**

Part 1: Provider & Patient Information

Provider Information		
Referring Pediatrician/Specialist		
Provider Name & Credentials:		
Phone:	Fax:	
Provider Delivering Services		
Practice Name:	Contact Name:	
☐ In-Network ☐ Out-of-Network	Practice NPI:	Tax ID:
Address:		
City:	State:	Zip Code:
Group Phone:	Group Fax:	
1. Name and Credentials of Supervising Provider delivering services:		
Phone:	NPI:	Fax:
2. Name and Credentials of Supervising Provider delivering services:		
Phone:	NPI:	Fax:

Patient Information		
Name:	Date of Birth: / /	Sex:
Address:		
City:	State:	Zip Code:
Subscriber Name:	Subscriber's Employer Group:	
Relationship to patient:	Phone Number:	

Family Information		
Parent/Guardian (1):	Relationship to Patient:	
Home Phone:	Other phone:	
Address: ☑ Same as patient	If Other:	
City:	State:	Zip Code:
Parent/Guardian (2):	Relationship to Patient:	
Home Phone:	Other phone:	
Address: ☐ Same as patient	If Other:	
City:	State:	Zip Code:

Part 2: Summary of Bio-psychosocial Information

A comprehensive Bio-psychosocial Evaluation should accompany this plan. If you choose to submit your own documents, please make sure to include all information outlined below. For reauthorizations, only complete this portion if there are changes to Bio-psychosocial information.

DSM 5 Diagnoses			
Strengths of the child			
Family Structure			
School placement (including homeschool instruction)			
Time in school per week (including days per week and hours per day)			
Specify recent major life changes			
Summary of Cognitive/Developmental Level and Language Functioning			

Part 3: Progress of Target Behaviors that are the Focus of Treatment

Initial Authorization Request: *Please include baseline level for the behavior or skill, target dates and mastery criteria for the treatment goals, and if they are short-term or long-term.*

Re-authorization Request: *Please describe progress toward target behaviors.*

1) Area of Concern (e.g. functional communication, social skills, self-help skills, etc.)	
Target Behaviors	Treatment Goals
Progress toward Treatment Goals (Re-auth only)	

2) Area of Concern (e.g. functional communication, social skills, self-help skills, etc.)	
Target Behaviors	Treatment Goals
Progress toward Treatment Goals (Re-auth only)	

3) Area of Concern (e.g. functional communication, social skills, self-help skills, etc.)	
Target Behaviors	Treatment Goals
Progress toward Treatment Goals (Re-auth only)	

4) Area of Concern (e.g. functional communication, social skills, self-help skills, etc.)	
Target Behaviors	Treatment Goals
Progress toward Treatment Goals (Re-auth only)	

Part 4: Approach to Intervention

Treatment Modality (e.g. Discrete Trial, Pivotal Response Therapy, Verbal Behavior Therapy, Early Start Denver Model, Floortime)
Intervention Setting(s)
Plan for Parent Training
Discharge Criterion

Part 5: Request for Services

For authorization and reimbursement of all ASD services, including ABA and BHRS, Quest requires the use of 2019 CPT codes. For more information on these codes, visit the Adaptive Behavior Assessment and Treatment Code Conversion Table at : https://www.bacb.com/wp-content/uploads/CPT_Codes_Crosswalk_.pdf

PROVIDER MODIFIERS: AH = BCBA/BCBA-D AJ = LBS/MT HN = RBT/BT HM = TSS

Provider Modifier	Service Code	Service Description	Hours per week			Treatment Dates Start-End	# of weeks	Total # of 15 minute units
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0
				x4	= 0			0

Treatment Plan Completed by		☐ Submit Roster of Providers
Treating Provider Signature:		
Date: / /	Phone:	Fax:

Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Quest Behavioral Health
PO Box 1032
York, PA 17402
Fax: 717-851-1414

For Internal Use Only		
Date Quest Received: / /	Date Quest Auth Sent: / /	Care Manager: