Horizon Blue Cross Blue Shield of New Jersey

Requested Start Date for this Authorization
____/____/____

❑ Concurrent Request

Patient Name: _____

Date of Birth: _____Age: _____ ❑ M ❑ F

Address (City/State only): _____

Tel #: _____Patient's Insurance ID#:_____

Patient's Employer/Benefit Plan: _____

Provider/Supervisor Name: _____

License _____ Certification # (if applicable)_____

Name of Program/Clinic (if applicable): _____

VO Provider ID # (if known): _____Tel #_____

Service Address: _____

City/State/Zip: _____

Independently licensed provider in State where treating patient? ❑ Yes ❑ No

ABA Provider Certification ❑ BCBA ❑ BCABA ❑ State certification

ID #: _____ *Check Which*: ❑ SSN ❑ Tax ID ❑ NPI

Additional Care Team Names (use additional sheets as necessary):

- Paraprofessional / Tutor: _____
  ❑ Attestation of qualifications by supervisor
- Paraprofessional / Tutor: _____
  ❑ Attestation of qualifications by supervisor
- **Consultant** : _____
  VO Provider ID # (if known): _____Tel #_____
  Service Address: _____
  City/State/Zip: _____
  Independently licensed provider in State where treating patient? ❑ Yes ❑ No
  ABA Provider Certification ❑ BCBA ❑ BCABA ❑ State certification
  ID #: _____ *Check Which*: ❑ SSN ❑ Tax ID ❑ NPI

Diagnosis: _____

- Qualified provider determining diagnosis (pediatrician, psychiatrist, MD, DO, independently licensed and credentialed psychologist):
  Name/Credential_____
  Tel # _____

Treatment History: (*please select all that apply in last 12 months*)

❑ Mental Health ❑ Substance Abuse ❑ Both ❑ None ❑ Unknown

❑ Outpatient ❑ Partial/IOP ❑ Inpatient ❑ Residential ❑ Group Home

❑ Other _____ ❑ Other _____

Previous ABA Treatment (date and location):_____

Applied Behavioral Analysis Treatment Report—Concurrent

Current Impairments: *(Please select one value for each type of impairment. Scale: 0=none; 1=mild/mildly incapacitating; 2=moderate/moderately incapacitating; 3=severe or severely incapacitating; na=not assessed.*

	Initial
• Danger to Self	0 1 2 3 na
• Danger to Others	0 1 2 3 na
• Communication	0 1 2 3 na
• Social Interactions	0 1 2 3 na
• Restrictive, Repetitive, Stereotypical patterns of behaviors	0 1 2 3 na
• Mood Disturbance (Depression or Mania)	0 1 2 3 na
• Anxiety	0 1 2 3 na
• Psychosis/Hallucinations/Delusions	0 1 2 3 na
• Thinking/Cognition/Memory/Concentration Problems	0 1 2 3 na
• Impulsive/Reckless/Aggressive Behavior	0 1 2 3 na
• Activities of Daily Living Problems	0 1 2 3 na
• Weight Change Associated with a Behavioral Diagnosis	0 1 2 3 na
• Medical/Physical Condition	0 1 2 3 na
• Substance Abuse/Dependence	0 1 2 3 na
• Job/School Performance Problems	0 1 2 3 na
• Legal Problems	0 1 2 3 na

*Please indicate type(s) of service provided **BY OTHERS** (select all that apply):*

❑ Medication Management	❑ Indiv. Psychotherapy	❑ Family Psychotherapy
❑ Group Therapy	❑ Community Program(s)	❑ Self Help Group(s)
❑ Occupational Therapy	❑ Physical Therapy	❑ Speech Therapy
❑ _____	❑ _____	❑ _____

I am coordinating this patient's case with other providers as appropriate.

- Behavioral ❑ Y ❑ N ❑ NA
- Medical ❑ Y ❑ N ❑ NA
- Community Services ❑ Y ❑ N ❑ NA
- Regional/State Program ❑ Y ❑ N ❑ NA
- Educational Program ❑ Y ❑ N ❑ NA

Current Medications including Psychotropic : Dosage and Frequency

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Treating Provider's Signature: _____Date: _____

Completed form can be faxed to: 855-241-8895 or
mailed to: Horizon BCBSNJ, Horizon Behavioral Health PO Box # 4274 Cherry Hill, NJ 08034

ABA CONCURRENT SERVICES REQUEST
*Please indicate type(s) of service provided **by care team in next 6 months** and requested hours per day and days per week*

Program Setting: ❑Home ❑Facility/Clinic ❑School ❑Other:

❑ **Adaptive Behavior Treatment** (Direct 1:1 ABA Therapy)

- **0364T, 0365T:** by technician, receiving 1 hr of supervision for every 5 to 10 hrs of direct treatment.
  ___ hours per day (based on 30 min. increments), ___ days per week
- **0368T, 0369T:** by MD/Qualified Health Care Professional (QHCP)
  ___ hours per day (based on 30 min. increments), ___ days per week
- **0373T, 0374T:** Exposure Adaptive Behavior Treatment requiring 2 or more technicians, for severe maladaptive behaviors
  ___ hours per day (based on an initial 60 minutes with additional 30 minute increments) by technician, ___ days per week

❑ **Group** Adaptive Behavior Treatment

- **0372T:** Social Skills Group by MD/QHCP,
  ___ hours per day (based on 30 minute increments), ___ days per week
- **0366T, 0367T:** Group Adaptive Behavior Treatment by Protocol by technician,
  ___ hours per day (based on 30 min. increments), ___ days per week

❑ **Assessment / Follow-up Assessment** by MD/QHCP. Behavior identification assessment, administration of tests, detailed behavioral history, observation, caretaker interview, interpretation, discussion of findings, recommendations, preparation of report, development of treatment plan. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis) and follow-up assessments

- **0359T:** Behavior Identification Assessment (initial), 60 minute increment
- **0360T/0361T:** Observational Behavior Follow-up Assessment, 30 min increment
- **0362T/0363T** Exposure Behavior Follow-up Assessment, 30 minute increments

Requested total hours for combined **0359T, 0360T/0361T, 0362T/0362T**

- ❑ 0-6 hours in 6 months (consistent with 5 hrs or less direct ABA/wk)
- ❑ 7-12 hours in 6 months (consistent with 10 hr direct ABA/wk)
- ❑ 13-18 hours in 6 months (consistent with 15 hr direct ABA/wk)
- ❑ 19-24 hours in 6 months (consistent with 20-40 hrs direct ABA/wk)

❑ **Family** adaptive behavior treatment guidance by MD/ QHCP, without patient

- **0370T:** with individual family.
  ___ hours per day (based on 30 minute increments), ___ days per week
- **0371T:** with multiple family group,
  ___ hours per day (based on 30 minute increments), ___ days per week

❑ Other _____ frequency:_____

Patient Name:_____ **ID#**_____
(name and ID are needed to ensure that both pages are for same individual)

Concurrent TREATMENT REPORT

ABA Provider Report Guidelines are available on ValueOptions.com (ATTACH your treatment report ensuring that all required details are covered)

I. RE-ASSESSMENT

Capabilities/Strengths

Current Problem Areas/Skill Deficits

- Social Interaction Impairments
- Communications Impairments
- Restricted, repetitive, stereotyped patterns of behavior, interests, and activities

Re-Assessment Description and Tools Used

Description of goals achieved within the recent authorization period

Summary of Family/Caregiver Involvement and Plan for Continued Participation/ Behavioral Management Skill Transfer

II. TREATMENT

Treatment Description

- Instructional Methods (ie DTT, PRT, Natural Environment
- Behavioral Methods (DRA, DRO, Behavioral Momentum
- Treatment Setting
- Description of supervision and direct service delivery process (who/what/when and
- frequency)
- Description of care coordination activities
- Summary of services delivered to date—by hour, code, provider

New or continued measurable objectives to address both behavior & skill deficits:

- Conditions in which skill/behavior is to occur, including generalized settings
- Behavioral definition of desired skill(s)/behavior(s) - **observable and measurable**
- Baseline data **(attach graphic display)**
- Current results data **(attach graphic display)**
- Behavior mastery criteria (quantify frequency and settings to demonstrate mastery)
- Recommendation/justification for continued treatment
- Skill(s) introduction target date
- Skill(s) mastery target date