Member: _____ ID#_____

FAX to 206-613-8873
ABA Therapy Initial Request Form
Service call 1-800-440-1561

Member Name: _____

DOB:_____**ID#:**_____**Group #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Requesting Provider: _____

Provider NPI #: _____

Service Address: _____

City:_____**State:**_____**Zip:** _____

Phone:_____**Fax:** _____

Treating Provider: _____

Provider NPI #: _____

Service Address: _____

City:_____**State:**_____**Zip:** _____

Phone:_____**Fax:** _____

DSM/ ICD- DIAGNOSIS numeric + description: _____

Axis I: _____
Axis II: _____
Axis III: _____

Psychotropic Medications
Prescribed by ❑ PCP ❑Psychiatrist ❑ APRN

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

If affective or psychotic disorder is present and no medications are prescribed, please explain:

_____
_____

Member: _____ ID#_____

Risk Assessment:

❑ Suicidal ❑ Ideation ❑ Planned ❑ Imminent Intent ❑ History of self-harming behavior
❑ Homicidal ❑ Ideation ❑Planned ❑Imminent Intent ❑ History of behavior harming others
❑ Danger to Self
- ❑ Frequently engages in self-injurious behavior
- ❑ Poor impulse control that might cause self-harm

❑ Danger to others/property
- ❑ Frequent verbal/non-verbal threats
- ❑ Tantrums/protest
- ❑ Aggressive acts to harm another person
- ❑ Frequent violent or uncontrolled behavior that endangers others or involves destruction of property

Functional Impairment

❑ Stereotyped/repetitive behaviors
- ❑ Repetitive mannerisms
- ❑ Rigid adherence to routines
- ❑ Restricted range of interests
- ❑ Preoccupation with one or few items/topics/etc

❑ Severe disruptive behaviors
- ❑ Significantly interfere with functioning
- ❑ Marked impairment in age appropriate social interactions

❑ Lack of age appropriate functional skills
- ❑ Lack of age-appropriate communication skills
- ❑ Lack of age-appropriate social skills and/or play skills
- ❑ Failure to independently engage in age-appropriate daily living skills and vocational skills

Treatment Plan:

❑ Consultation Report Attached
❑ Functional Behavioral Assessment Attached
❑ Treatment Plan Report Attached
- ❑ Parent/caregiver training will be provided in treatment plan
- ❑ Treatment providers are Board Certified Behavior Analysts (BCBA) or Board Certified Assistant

Therapy Services Requested:

Therapy Services	CPT Code	Units Requested Per Week/Month (please indicate if weekly or monthly units)	Requested Start Date

Requesting Provider Signature:_____ Date: _____