Health Services for Children with Special Needs, Inc. (HSCSN)

Provider Request for ABA Evaluation

This form should be completed by a provider who has knowledge of the enrollee's current clinical presentation and his/her treatment history. Please attach copies of reports and materials that will be helpful in reviewing this request. Fax all requests and supporting documents to the Utilization Management department at **202-721-7190**.

Date of Request:		
Enrollee Name:	Enrollee ID Number:	DOB: Circle: ○M F ○
Name of requesting provider:		Phone/Fax/Email:
Relationship of enrollee to the member (e.g., PCP, neurologist etc):		

Patient Diagnosis (current)

Primary Diagnosis	
Co-occurring psychiatric diagnoses	
Co-occurring medical diagnoses	

What are the child's current behavioral problems to be addressed with ABA therapy?

Aggression: verbal, physical, injurious or destructive behavior such as biting, kicking, punching, destruction of property, self-injurious behavior such as head banging, pulling out hair, burning, branding or rubbing skin to produce sores or scars

Extreme Impulsivity: includes daredevil behavior that involves risk-taking that could be a danger to self and/or elopement behaviors

Overt Agitation: child having problems managing the following: vocalizations, upper extremity movements, lower extremities; frustration tolerance; stereotyped/repetitive behaviors

Non-compliant behavior: unwilling to follow the simplest of rules; requires constant re-direction; requires constant supervision

Emotional Instability: angry outbursts with increasing frequency and intensity, mood lability

Does the child's behavior interfere with their day to day functioning?

Home School Community

For children age 4 and above, please attach the IEP or provide an explanation as to why it is not included.

_____

_____

Signature of requesting provider:_____ Date:_____

HSCSN use only:

ABA Evaluation authorized: Yes No

Signature of UM staff: _____ Date:_____