

## HSCSN PROVIDER REQUEST FOR ABA EVALUATION



This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at Fax: 202-721-7190 or email: [UM@hschealth.org](mailto:UM@hschealth.org).  
**IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.**

<b>DATE OF REQUEST:</b>	
<b>PROVIDER</b>	<b>MEMBER</b>
Ordering Provider (MD or NP):	Member Name:
Provider NPI #:	Member ID: <span style="float: right;">DOB:</span>
Provider Phone #: Fax #:	Primary Diagnosis:
Provider Email:	Other Diagnoses:
<b>SUPPLEMENT REQUESTED</b> (Include schedule of supplement): Name of Supplement: Routed: <input type="checkbox"/> By Mouth <input type="checkbox"/> By Tube <input type="checkbox"/> Combo Amount/Schedule: Proposed Duration of Use: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	
<p><b>What are the child's current behavioral problems to be addressed with ABA therapy?</b></p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Extreme Impulsivity: includes daredevil behavior that involves risk-taking that could be a danger to self and/or Elopement Behaviors</p> <p><input type="checkbox"/> Overt Agitation: child having problems managing the following: vocalizations, upper extremity movements, lower extremities; frustration tolerance; stereotyped/repetitive behaviors</p> <p><input type="checkbox"/> Non-compliant behavior: unwilling to follow the simplest of rules; requires constant re-direction; requires constant supervision</p> <p><input type="checkbox"/> Emotional Instability: angry outbursts with increasing frequency and intensity, mood lability</p> <p><b>Does the child's behavior interfere with their day to day functioning?</b></p> <p style="text-align: center;"><input type="checkbox"/> Home                      <input type="checkbox"/> School                      <input type="checkbox"/> Community</p> <p><b>For children age 4 and above, please attach the IEP or provide an explanation as to why it is not included.</b></p>	

Signature of requesting provider: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

<b>HSCSN use only:</b>	
ABA Evaluation authorized: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of UM staff: _____	Date: _____