Lucet™ | The Behavioral Health Optimization Company

Autism Resource Program: 877-563-9347 Fax: 816-237-2372

Pre-Treatment Assessment Request for Applied Behavioral Analysis for Autism Spectrum Disorder

Please complete all parts as clearly and as specifically as possible. Illegibility may result in a delay in the authorization. Omissions and generalities could result in a peer review or denial due to lack of information.

Identifying Data	
Member's Name:	Member ID #:
Date of Birth:	Age:
Current Diagnosis Code(s):	
Diagnosed by:	Diagnosis Date:
State where member is being treated:	
MD/PhD Name:	MD/PhD Phone:

Parent/Guardian Information	
Parent/ Guardian Name(s):	Contact Number(s):
Parent/ Guardian Email Address:	*Please note, if member is age 18 or above, guardianship paperwork will need to be submitted Authorized Delegate Form

Provider Information	
Contact Name:	Contact Phone Number:
Contact Email:	Provider Group Name:
Provider Group Tax ID:	Provider Group Address:

Behavior Analyst Name:	Behavior Analyst Individual NPI:
Behavior Analyst Phone:	Behavior Analyst Fax:
Behavior Analyst Email:	Confirmation the Behavior Analyst is in-network with local blue? ☐ Yes ☐ No

Authorization Information

Requested Assessment Date:	Assessment Code(s) and Hours Requested:
Please list assessments Behavior Analyst plans to utilize during initial assessment (i.e. VBMAPP, ABLLS, AFLS, Vineland, etc.):	

Code	Hours Requested

Has member previously been in ABA? ☐ Yes ☐ No

If yes to above, please indicate previous providers and dates of ABA services:

Has previous treatment plan been reviewed by the Behavior Analyst? ☐ Yes ☐ No

Future Submissions

Did you want us to create a WebPass account for you so you can submit future requests through our online portal? ☐ Yes ☐ No

If yes, please answer the following to be used for a WebPass account:
Name:
Provider Group Tax ID:
Email:

If you select yes, you will receive a time sensitive email to set up your password and an email with PowerPoint instructions on how to utilize WebPass.

Submission Checklist- Please contact 877-563-9347 with any questions	
All evidence-based screening and scaling results used in determining the diagnosis must be submitted with this request as required by individual state mandate. Please refer to the Provider Manual for additional information regarding specific screenings and scales.	
Did you include a complete diagnostic evaluation, including an ASD-specific standardized assessment, completed by a clinician who is licensed and qualified to make such a diagnosis confirming member has ASD dated within past 5 years?	☐ Yes ☐ No *Required for initial assessment
Did you include a referral signed by a QHP with a diagnosis of ASD recommending ABA dated within the past year?	☐ Yes ☐ No If no, this will need to be submitted with the initial treatment request
Did you include a Wellness Check completed by the primary care physician, including a Review of Symptoms (ROS) with a neurological component, dated within the past year?	☐ Yes ☐ No If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment
Did you include a cognitive/ developmental evaluation dated within past 5 years?	☐ Yes ☐ No If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment
Did you include an Adaptive Behavioral Evaluation dated within past six months?	☐ Yes ☐ No If no, this will need to be submitted within the first 90 days of treatment or scheduled date for appointment
Please note, requirements for Arkansas/ Walmart policies also require the following to be submitted within the first 90 days of treatment: ☐ Speech Evaluation by a licensed speech therapist ☐ Sensorimotor evaluation ☐ Hearing evaluation	
Please note, requirements for State of Kansas also require the following to be submitted within the first 90 days of treatment: ☐ Speech Evaluation by a licensed speech therapist ☐ Lead poisoning assessment ☐ Hearing evaluation	

Education Information (Optional)
Grade:
Schools Attended:
Any special education or services provided?
Does member have an IEP? ☐ Yes ☐ No If yes, please include a copy