



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

For administrative questions, please contact [autismadmin@lucethealth.com](mailto:autismadmin@lucethealth.com). For clinical questions, please contact your Autism Care Manager or the autism department at 877-563-9347.

### **Pre-Treatment Assessment Request for Applied Behavior Analysis for Autism Spectrum Disorder - Revised Dec. 2024, Last Reviewed Nov. 2025**

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.

<b>Member Information</b>	
Member's Name:	Member ID #:
Date of Birth:	Age:
Current Diagnosis Code(s):	
State where member is being treated:	
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 <a href="#">Authorized Delegate Form</a>
<b>Provider/ Group Information</b>	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.):	<table border="1"> <thead> <tr> <th align="center">Code</th> <th align="center">Hours Requested</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Code	Hours Requested								
	Code	Hours Requested									

Location of assessment:  Home  Community  Clinic  School  
 Other: \_\_\_\_\_

I attest that I have verified benefit coverage for these proposed places of service for assessment.

**Attestations**

I attest I have read the diagnostic requirements in the ABA Medical Policy listed on [lucethealth.com](http://lucethealth.com)

Attestation that all services are provided in a manner consistent with the Lucet Provider Manual, the Behavior Analysis Certification Board's Ethics Code for Behavior Analysts or relevant ethics code, generally accepted standards of care, and applicable state laws.

I attest this member has a diagnosis of autism from a qualified healthcare professional and I will submit the comprehensive diagnostic evaluation with the initial treatment request.

**Additional Relevant Information**

**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.

**Please contact 877-563-9347 with any questions**