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

For administrative questions, please contact 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

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.

Member Information	
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 Authorized Delegate Form
Provider/ Group 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

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

☐ 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.

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.

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 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	