



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 - 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.

| 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? <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 | | | | | | | | |
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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

I attest 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