Request for Medicaid State Plan Coverage of Applied Behavioral Analysis for a Child Under Age 21

Patient Name: ______________________ Date of Birth: ____________ Medicaid ID: ____________

Mailing Address: ____

Street Address *City* *State* *Zip*

This section must be completed by a physician

Requesting Physician Name: ____________ National Provider ID: ____________ Telephone: ________ Fax: ________

Mailing Address: ____

Street Address *City* *State* *Zip*

Diagnosis of Patient: ______________________ Diagnosis Code: ____________
(299.0-299.9)

Is a behavioral analysis assessment needed? Yes ☐ No ☐

If the child has been assessed, what is the expected frequency/duration of treatment? ____________

What is the primary focus of treatment:

☐ Maladaptive target behavior is of a severity that the child's personal safety, or the safety of others in the child's environment, is jeopardized or very significantly or even completely interferes with ability to function?

☐ Developing social and communication skills to allow the child to fit into environments with their typically developing peers?

Is the parent willing to participate in the child's treatment? Yes ☐ No ☐

Requestor's Signature and Credentials: ______________________ License #: ____________ Date: ________

Please attach related medical records that document the child's diagnosis of autism spectrum disorder

Send completed form and attachments to your local Medicaid area office

DRAFT 3/30/12