Request for Authorization: Autism Spectrum Disorder Testing

Kansas | Healthy Blue | Medicaid

Please submit this form electronically using our preferred method by logging on to Availity Essentials from the Healthy Blue provider website at https://www.healthybluekansas.com/provider.

General information

Member name:	
Member date of birth:	Member ID #:
Professional administering testing:	
Provider name, if different than the professional administering the testing:	
Provider phone:	Provider fax:
Provider NPI:	Provider Tax ID:
Provider address:	
Provider email:	
Billing facility/group name:	
Billing facility/group NPI:	Billing facility/group tax ID:
Billing facility/group address:	
Are services being rendered in person or via telehealth:	
Servicing address:	

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders. Psychological testing is not indicated for the administration of brief behavior rating scales and inventories. **Such scales and inventories are an expected part of a routine and complete diagnostic process.** Other than in exceptional cases, the psychologist should complete a diagnostic interview and relevant rating scales prior to submission of requests for psychological testing authorization. Requests for placement purposes, disability evaluations, and forensic purposes are not covered benefits. You should refer requests for educational testing or assessment of learning disabilities to the public school system. **This form is for autism spectrum disorder testing requests only. You must complete requests for psychological or neuropsychological testing on their requisite forms.**

Clinical assessment: Indicate which of the following assessments were completed.

KSHB-CD-066296-24-SRS66052 November 2024

☐ Psychiatric and medical history	☐ Medical evaluation (complete medical history and physical examination with hearing and vision screening)	☐ Consultation with school/other important persons
☐ Clinical interview with patient	☐ Developmental screening evaluation by physician or psychologist	☐ Review of academic records/IEP
☐ Interview with family members	☐ Evaluation by speech-language pathologist	☐ Brief inventories and/or rating scales
☐ Direct observation of patient	☐ Structured developmental and social history	☐ Family history pertinent to testing request

Please attach any relevant clinical/medical records to support the testing request.

Date of diagnostic interview: _____

Rating scales: Please indicate which rating scales have been administered as part of your clinical assessment (prior to submitting the testing request).			
☐ ASRS	☐ SCQ	☐ SRS	☐ MCHAT
☐ CARS	☐ GARS	☐ GADS	☐ Other:
Other(s):			
Rating scale results:			

Treatment history: Please provide information regarding treatment history.				
	How often does the member receive services?	**How long has the member been in treatment?**	**Is member still in treatment?**	**Have the member's symptoms improved?**
Mental health/behavioral therapy:	☐ Weekly ☐ Bi-weekly ☐ Monthly		☐ Yes ☐ No	☐ Yes ☐ No
Medication management:	☐ Weekly ☐ Bi-weekly ☐ Monthly		☐ Yes ☐ No	☐ Yes ☐ No
Speech therapy:	☐ Weekly		☐ Yes ☐ No	☐ Yes ☐ No

	☐ Bi-weekly ☐ Monthly			
Occupational therapy:	☐ Weekly ☐ Bi-weekly ☐ Monthly		☐ Yes ☐ No	☐ Yes ☐ No

Other pertinent information

Please include any other information that supports the request for ASD testing.

Previous ASD testing

Please include any information regarding previous ASD testing (for example, dates of testing and results) and why retesting is requested.

DSM-5/ICD-10-CM diagnosis under evaluation

Code(s)	**Current or provisional**
	☐ Current ☐ Provisional
	☐ Current ☐ Provisional
	☐ Current ☐ Provisional
	☐ Current ☐ Provisional
	☐ Current ☐ Provisional

Rationale for testing: Please describe the rationale for testing.

What are the current questions needing answers that cannot be addressed by the clinical interview, review of records and rating scales that you previously administered?

How will the results of testing impact the course of treatment?

Is this a request to access ABA services? ☐ Yes ☐ No

Psychological tests requested
Please list the tests you are requesting and the administration time. For tests with multiple versions, specify which version. If you are administering selected subtests, please indicate which subtests. Please attach a separate sheet if necessary.

Code(s): Please select	Unit(s) requested
☐ **96112** (may not require prior authorization)	
☐ **96113** (may not require prior authorization)	
☐ **96130** or ☐ **96132** (only one unit allowed)	
☐ **96131 or** ☐ **96133**	
☐ **96136** (only one unit allowed)	
☐ **96137**	
☐ **96138** (only one unit allowed)	
☐ **96139**	
Total units requested:	**Total time requested:**

Provider signature: _____ Date: _____

If unable to submit this form via Availity Essentials, you may fax to **866-852-8978** prior to rendering services.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.