KanCare | Healthy Blue

Autism Spectrum Disorder (ASD) Services Request Form

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**. Please include behavioral analyst information and *Treatment Plan Request Form*.

Please print clearly — incomplete or illegible forms may delay processing and be returned.

Member information		
Member name:		
Address:		
Member ID:		
Date of birth:		
Gender: ☐ M ☐ F ☐ Other		
Caregiver name:		
Phone number:	Email:	
Diagnosis:	Diagnosed by whom?	
Agency information:		
Agency name:		
TIN:		
NPI:		
Provider phone:	Is voicemail confidential? ☐ Yes ☐ No	Fax number for approval:
Network status: ☐ In network ☐ Out of network		
Servicing address street:		
City:	State:	ZIP:
Contact person:		
Phone:	Email:	

BCBA or rendering provider information		
Provider name: (include licensure or certification):		
TIN/NPI:		
Address (if different from above):		
Phone number:	Is voicemail confidential? ☐ Yes ☐ No	Email

Assessment, treatment information, and recommendations

For initial assessment requests when requesting **only** 97151/97152 and or if a member has new insurance coverage, one of the following must be included:

- Diagnostic evaluation/report completed by a doctorate level clinician, a physician (MD), or other approved licensure per Kansas state regulations, along with a recommendation for ABA services

Please attach treatment plan

The treatment plan should be dated within 30 days of the start date. We recommend including the following in your request:

- Statement of any previous interventions for ASD and outcomes.
- Current behavioral support plan including symptoms and behaviors requiring treatment.
- Cumulative graphs/charts of baseline data and current progress for behaviors to be decreased only.
- Description of progress on goals since last review.
- Baseline and yearly assessment (such as Vineland, VB Mapp, ABLLS-R) to show progress toward goals is occurring.
- List any other services the member is receiving (for example, PT, OT, ST, school, behavioral health) and coordination of care with other providers noted.
- Description of treatment setting(s).
- Schedule of treatment (hours per day/week) for all requests.
- Documentation of changes in parental/caregiver/guardian situation, if applicable, since the last review plus measurable goals for parent training
- Measurable, client-specific plans for generalization. If home and community generalization is not possible, then describe the behaviors that are preventing generalization.
- Measurable, client-specific discharge/transition plan. May address plan for transition from comprehensive to focused ABA treatment.

Age of first ABA treatment:	Start of current request:

Service description	Units	CPT® code	Timeframe (weekly/monthly)
Behavior identification assessment, each 15 minutes		97151	Per authorization period
Behavior identification supporting assessment, each 15 minutes		97152	Per authorization period
Adaptive behavior treatment by protocol, each 15 minutes		97153	
Group adaptive behavior treatment by protocol, multiple patients, performed by a registered behavioral technician (RBT)		97154	
Adaptive behavior treatment with protocol modification, each 15 minutes		97155	
Family adaptive behavior treatment guidance, each 15 minutes		97156	
Group adaptive behavior treatment by protocol, multiple patients, performed by a board-certified behavior analyst (BCBA)		97158	

Provider name (print): License information:

Provider signature Date:

This form can also be submitted via fax to 866-852-8978.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled with 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.