ABA Referral Form A: Assessment Authorization Request

This form is to be completed and submitted to Health Share Pathways' Behavioral Health Plan Partner by only **developmental pediatricians and other providers** (physicians, physician's assistants, psychologists and nurse practitioners) who have experience and training in the diagnosis of an Autism Spectrum Disorder. (Forms received from any other type of provider cannot be processed.) Individuals must have a **medical** diagnosis of **Autism Spectrum Disorder** or **Stereotypic Movement Disorder** that has been substantiated with a comprehensive assessment.

Please attach a Comprehensive Diagnostic Evaluation of ASD with this request.

Insurance Eligibility Information **** Section Required****
Member Medicaid ID:
Member's Health Share Behavioral Health Plan *(please select one)*: ☐ Multnomah County Behavioral Health Plan ☐ Clackamas County Behavioral Health Plan ☐ Washington County Behavioral Health Plan
To verify member eligibility, please look in CIM or contact Health Share Customer Service at 503-416-8090 or 1-866-519-3845
Other Primary Insurance Information *(if applicable)*
Check Type of Members Primary Insurance and Complete Plan Information: ☐ Medicare Primary / Medicaid Secondary (Co-Pay Only) ☐ Third Party Insurance
Carrier:
Group/Policy Number:
Effective Date:
☐ Not Applicable, member does not have other primary insurance

Member Demographic Information **** Section Required****		
First Name:	MI:	Last Name:
Date of Birth:		Gender:
Race/Ethnicity *(optional)*:		
Member Preferred Language:		
Street Address:		
City:	State:	Zip:

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Member Demographic Information *Continued*	
Name of Legal Guardian:	Relationship:
Legal Guardian Preferred Language:	
Legal Guardian Contact Phone:	
Legal Guardian Email Address:	
Name of Caregiver:	Same As Legal Guardian ☐
Caregiver Preferred Language:	
Caregiver Contact Phone:	
Caregiver Email Address:	

Referent Information ** Section Required**	
Referring Provider:	Agency/Role:
Phone:	Fax:
Email:	

Contact Person *(if different than Referring Provider)*	
Contact:	Agency/Role:
Phone:	Fax:
Email:	

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Care Coordination Information ***Please complete required sections and complete as much information as possible***
School/Early Intervention ***Required***
Name:
School District:
Contact Info:
Current Education Plan: ☐ IEP ☐ 504 Plan ☐ ISFP
Primary Care Provider
Name:
Contact Info:
Mental Health Provider
Name:
Contact Info:
Dental Provider
Name:
Contact Info:
Developmental Disabilities Provider
Name:
Contact Info:
Medication Management Provider
Name:
Contact Info:
DHS Child Welfare Worker
Name:
Contact Info:

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Autism Spectrum Disorder and Other Diagnoses ** Section Required**
Medical Diagnosis of ASD or SMD:
Date of Diagnosis:
Developmental Diagnostic Tool(s) Used: ☐ Vineland ☐ ABA-S ☐ Other:
Standardized Validated Tool(s) Used to Determine Medical Diagnosis of Autism: ☐ ADOS ☐ CARS ☐ Gilliam ☐ Other:
Other Relevant medical and mental health diagnoses (if applicable):
ASD Diagnosing Provider Full Name (with credentials):
ASD Diagnosing Provider Agency:

ABA Provider Preferences
We have several ABA providers who are contracted to provider ABA services to Health Share Members. **Parent/Caregiver participation is recommended.** Please note any ABA service preferences below: ☐ Home-based ☐ Office-based ☐ No ABA Provider preference / 1st Available ABA Provider Request (please indicate preferred ABA Provider Below) Preferred ABA Provider:

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Clinical Documentation Checklist ** Section Required**
Please include **all** of the following information for a complete request: ☐ Completed ABA Referral Form A: Initial Assessment for Services ☐ Comprehensive Assessment which includes all of the following: ☐ Documentation of and results from a standardized and validated tool, such as the ADOS or CARS, that has been used to substantiate the Autism Spectrum Disorder ☐ Documentation of developmental status using a validated and validated tool, such as the Vineland or ABAS ☐ Documentation of individual core features of Autism Spectrum Disorder as defined in the DSM-5

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Upon completion of this form, please submit, with appropriate clinical documentation, to the member's assigned **Behavioral Health Plan Partner, Attn: Youth Intensive Care Coordination (ICC)**:

- **Clackamas County Behavioral Health:** Phone: 503-742-5937 | Fax: 503-742-5304
- **Multnomah County Behavioral Health:** Phone: 503-988-4161 | Fax: 503-988-3328 | Email: aba.carecoordination@multco.us
- **Washington County Behavioral Health:** Phone: 503-291-1155 | Fax: 503-846-4560 | Email: ABA@co.washington.or.us

This form should never be sent directly to the ABA Provider.

Complete and valid requests will be reviewed by the ICC team at the appropriate Behavioral Health Plan Partner and a determination will be made within **14 calendar days** of a completed request being submitted.

The referent will be notified of approved authorization or a denial of services. If the authorization is approved, a referral to a contracted ABA provider will be provided by the Behavioral Health Plan Partner.

Any ABA Referral Form A received by the Behavioral Health Plan Partner which is missing the diagnostic report cannot be processed.