ABA Referral Form B: Treatment Request

This form is to be completed and submitted by **Board Certified Applied Behavioral Analysis (ABA)** providers to request an initial authorization or re-authorization for ABA Treatment Services

Insurance Eligibility Information **Section Required**
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 Information **Section Required**		
First Name:	MI:	Last Name:
Date of Birth:	Gender:	
Race/Ethnicity *(optional)*:		
Member Preferred Language:		
Interpretation Service Used: ☐IRCO ☐Passport to Languages ☐Linguava ☐Telelanguage ☐N/A – No Interpretation Services Needed		
Street Address:		
City:	State:	Zip:

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Member 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:	

Requesting Provider 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 **Section Required**
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:
List all current medications and current doses:
☐ N/A – Member does not have a Medication Management Provider
DHS Child Welfare Worker
Name: Contact Info:
☐ N/A – Member does not have a DHS Child Welfare Worker

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Care Coordination Information *Continued*	
Substance Use Disorder Provider	
Name:	Contact Info:
☐ N/A – Member does not have a Substance Use Disorder Provider	
School/Early Intervention	
Name:	Contact Info:
School District:	
Current Education Plan: ☐ IEP ☐ 504 Plan ☐ ISFP	
Other Services/Therapies	
Check all that apply: ☐ PT ☐ SLP ☐ OT ☐ Audiologist ☐ Optometrist ☐ Other: ☐ N/A – Member does not receive other services	
Name of Provider:	Type of Provider:
Contact Info:	
Name of Provider:	Type of Provider:
Contact Info:	

Requested Services **Section Required**	
Date of Initial ABA Assessment:	Date of Updated Documentation:
Authorization Date Range:	
Requested Hours per Week:	
Amount Requested per 6 Months*: $	
***Requested Amount not guaranteed.**	

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Clinical Documentation Checklist **Section Required**
Initial Request
Please include **all** of the following information for a complete request: ☐ Completed ABA Referral Form B: Request for Treatment ☐ Current ABA Assessment ☐ Proposed ABA Treatment Plan that includes D/C criteria
Continuation of Services Request
Please include **all** of the following information for a complete request: ☐ Completed ABA Referral Form B: Request for Treatment ☐ Documentation and tracking of progress and updated standardized assessment tools used to assess progress ☐ Updated ABA Treatment Plan that includes D/C criteria

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

Requests will be reviewed by the 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.