SUBMIT TO:
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
PHONE 1-877-644-4613 | FAX 1.866.270.4489

Applied Behavioral Analysis Treatment Form

Please write clearly and only in designated areas. Incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Name ____

Medi-Cal ID # ____

Date of Birth ____________________________________

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ____

Credentials ______________________________________

Address ____
City/State/Zip Code

Phone______________________Fax __________________

NPI________________________Tax ID _______________

Service Requested__________________________# of units______

Timeframe requested (that corresponds with Plan of Care)_________to ________

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ____

Credentials ______________________________________

Address ____
City/State/Zip Code

Phone______________________Fax __________________

NPI________________________Tax ID _______________

Service Requested__________________________# of units______

Timeframe requested (that corresponds with Plan of Care)_________to ________

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ____

Credentials ______________________________________

Address ____
City/State/Zip Code

Phone______________________Fax __________________

NPI________________________Tax ID _______________

Service Requested__________________________# of units______

Timeframe requested (that corresponds with Plan of Care)_________to ________

CURRENT DIAGNOSIS

Primary (Required): ________

Secondary: ______________________________________

Tertiary: ____

Additional: ______________________________________

Additional: ______________________________________

CURRENT PRESENTATION/SYMPTOMS

Describe the CURRENT situation and symptoms and the impact on current functioning (occupational, academic, social, etc.).

	Mild	Moderate	Severe
__________________________________	☐	☐	☐
__________________________________	☐	☐	☐
__________________________________	☐	☐	☐

MH/SA Treatment History - What has the member received in the past?

☐ NONE ☐ OP MH ☐ OP SA ☐ IP MH ☐ IP SA/DETOX ☐ OTHER

MEDICAL CONDITIONS AS REPORTED BY PARENT/GUARDIAN

RE EVALUATION REQUESTS

Medication name _____ Dosage _____

Medication name _____ Dosage _____

Medication name _____ Dosage _____

COORDINATION OF CARE

Coordination has occurred with

PCP: ☐ Yes ☐ No Psychiatrist: ☐ Yes ☐ No

No treatment history

Name of Behavioral Health Specialist _____

Treatment plan has been reviewed with BH care coordinator:

☐ Yes ☐ No

Parent/guardian agrees with treatment goals: ☐ Yes ☐ No

TREATMENT PROGRESS

In addition to the information on this form, please attach:

- Treatment plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
- Identify SMART goals in specific, behavioral and measurable terms and progress made toward treatment goals, or if no progress reason why and plan to address lack of progress.
- Comprehensive Diagnostic Report (initial request only)
- List any other services the member is receiving (i.e PT/OT/ST/school)
- A sample schedule of treatment
- Documentation of parental involvement, parent goals

Information older than 30 days will not be accepted for concurrent review.

_____ _____

Provider Name and License/Credential Date

Intake Assessment and Initial Behavior Change Plan must be attached for initial authorization. For concurrent review a treatment plan summary, the level of support requirement tool and the DSM-5 checklist tool must be attached.

_____ _____

Provider Signature Date

Have any questions?
Call us at 1-877-644-4613

www.coordinatedcarehealth.com