FirstChoice℠
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

Autism Spectrum Disorder (ASD) Treatment Request Form

Please print clearly — incomplete or illegible forms will delay processing. Please fax to: First Choice by Select Health of South Carolina's (Select Health) Behavioral Health Utilization Management (BHUM) department at **1-888-796-5521**. For assistance contact: **1-866-341-8765**.

Member information

Patient name:	Legal guardian:	Member date of birth:
Medicaid/Health plan #:	Last authorization # (if applicable):	

Provider information (board-certified behavior analyst [BCBA]/licensed provider)

Group/agency name:	☐ In network ☐ Out of network ☐ In credentialing process	
Provider name:	Provider credential: ☐ MD ☐ PhD ☐ LIP ☐ BCBA ☐ BCaBA ☐ RBT I ☐ RBT II	
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Physical address:	Phone number:	Fax number:
Medicaid/Provider/NPI #:	Contact name:	

Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis

Primary DX:	Secondary DX:	Medical DX:
Is the member diagnosed with an ASD?		

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to Select Health's BHUM department for a medical necessity determination. A failure to submit all clinical documentation may delay processing this request.

1. Diagnostic evaluation/report (initial requests).
2. Full behavior support plan/treatment plan (including symptoms/behaviors requiring treatment, specific treatment interventions, and that these were indicated by the assessment tool).
3. Applied behavior analysis (ABA) therapy progress summary, including cumulative graphs of progress/standard celeration charts.
4. Sample schedule of treatment.
5. Documentation of caregiver goals, involvement in treatment, and progress in skill development.

Additional information: _____

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DOCUMENTATION OF CARE COORDINATION IS A SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AUTISM SPECTRUM DISORDER (SCDHHS ASD) SERVICE MANUAL REQUIREMENT. Providers **MUST** complete this section of this form or may attach a separate document providing this information. List of any other services the member is receiving, including service names/therapy; number of hours per week of each treatment and the targets of those treatments; and evidence of coordination with school, preschool, or early intervention program and other therapy providers (coordination that is more than a phone call or notification of enrollment).

School/preschool/early intervention program **(Required)**:

Type of service	Number of hours/week	Behaviors/deficits targeted

Other therapies provided **(Required)**:

Type of service	Number of hours/week	Behaviors/deficits targeted

Summary of contact with other providers **(Required)**:

Treatment request:

Treatment start date:

ASD treatment	Units	CPT code	Time frame (weekly/monthly)	Limitation reminders
Behavior identification assessment (ABA)		97151		32 units per assessment BCBA/BCaBA required
Group adaptive behavior treatment by protocol, multiple patients by RBT		97154		24 units per day RBT required
Adaptive behavior treatment with protocol modification		97155		64 units per month BCBA/BCaBA required
Adaptive behavior treatment by protocol		97153		160 units units per week RBT required
Family adaptive behavior treatment guidance		97156		96 units per year BCBA/BCaBA required
Group adaptive behavior treatment by protocol, multiple patients by BCBA		97158		24 units per day BCBA/BCaBA required
Therapeutic behavioral service		H2019		Four units per week PhD, MD, LISW, LMFT, LPC, LPES required

Provider signature with credentials and date:

My signature confirms that any paraprofessional under my supervision has the appropriate education, t raining, and certifications as applicable.