Adaptive Behavior Treatment (ABT) Request for Initial Authorization

*BCBSNC Behavioral Health Service Administrator

Please provide the following information, including diagnostic assessment
by **fax to 1-888-656-4930, Attention: ABT Support Team**
Phone number for ABT Support Team: 800-359-2422

MEMBER INFORMATION:
Member name:
Member's date of birth:
Insurance ID#:
Member's phone number:
Name of parent(s)/guardian(s):
Language/cultural issues:

AGENCY/PROVIDER INFORMATION:
Agency name:
Phone number:
Mailing address:
Fax:
MIS/TIN #:
Agency contact name and phone number:
Case manager:
Supervisor name and phone number for clinical questions:

REQUESTED SERVICES:
Location:
T codes:
Number of hours:

START DATE OF SERVICES/AUTHORIZATION REQUEST:

REASON FOR REFERRAL:
Please identify the severe challenging behaviors that present a health or safety risk to self or others *or* significantly interfere with home or community activities.

- ☐ Health risk
- ☐ Self-injury
- ☐ Aggression toward others
- ☐ Destruction of property
- ☐ Stereotyped/repetitive behaviors
- ☐ Elopement
- ☐ Severe disruptive behavior

ASSESSMENT TOOL USED FOR DIAGNOSIS AND FINDINGS:

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CURRENT DSM-5 DIAGNOSIS:

SPECIFY ASD DIAGNOSTIC CRITERION MET PER DSM-5:

DATE ASD DIAGNOSIS ESTABLISHED AND BY WHOM: Please include documentation

DEVELOPMENTAL EVALUATION COMPLETED? : Y/N

OT EVALUATION COMPLETED?: Y/N

SPEECH AND LANGUAGE EVALUATION COMPLETED?: Y/N

OTHER EVALUATION & DIAGNOSIS TESTS TO RULE OUT OTHER CONDITIONS COMPLETED?:

LIST MEDICATIONS (Please include frequency and dosage):
Is the member medication adherent?

MEDICAL ISSUES:
OTHER PHYSICAL FACTORS:
Date and results of last physical exam:
Date and results of last dental exam:
Date and results of last hearing exam:
Date and results of last vision exam:

SPECIAL SUPPORT SERVICES (Provided by the school district, regional center or early childhood program): Please describe. If IEP, please include copy.

GOALS (List 2-3 critical behaviors to be the focus of treatment for the next 6 months):

AREAS OF FUNCTIONING EXPECTED TO IMPROVE BY NEXT REVIEW:
For each behavior, please provide the following:

- Define behavior-
  - Frequency (hourly/daily/weekly)
  - Duration (seconds/minutes/hrs)
  - Intensity (1=low: 10=severe)
- Baseline data- include events, situations, circumstances and environmental factors
- History of behavior