



For questions, please call: Blue Cross Community Health Plans (BCCHP): 877-860-2837 Blue Cross Community MMAI (Medicare-Medicaid Plan)SM: 877-723-7702

After completing the form, please fax to 312-233-4099.

PATIENT INFO

Patient Name Patient Date of Birth Request Submission Date Subscriber Name Subscriber ID Group Patient resides in what state? Services conducted in same state? Yes No If no, what state?

DIAGNOSTIC PRACTITIONER INFO

Diagnostic Practitioner Name NPI Telephone Fax Contact Name

Diagnostic Practitioner Type, if PCP: Family Practice Internal Medicine Pediatrics

Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider: Developmental Behavioral Pediatrics Neurodevelopmental Pediatrics Child Neurology Adult or Child Psychiatry Licensed Clinical Psychology Other (specify)

Primary Diagnosis Code Secondary Diagnosis Code Dates of Initial Evaluations / /

AUTHORIZATION/COMMUNICATION SENT TO

Facility Name NPI Address City State Zip Code Telephone ext Fax Contact Name

BCBA Name NPI License/Cert Address (if not same as above) City State Zip Code Telephone ext Fax Contact Name

PROVIDER REQUEST

Assessment Request Start Date / / to End Date / /

Table with 3 columns: ABA Assessment Code Request (Total Units for Assessment Period; 1 Unit = 15 minutes), 97151 QHP, 97152 Technician

Additional Code(s) Request and Reason

CERTIFICATION OF PROVIDER QUALIFICATIONS

ABA Supervisor Signature Date ABA Supervisor Printed Name Clinic Name

