Autism Spectrum Disorder Services Request Form

Please fax completed forms to 1-800-505-1193.

Member information

Name: _____

DOB: _____

Amerigroup Kansas, Inc. ID: _____

Provider information

_____

Name (include licensure/certification)

_____

TIN/NPI

_____

Street address

_____

City State ZIP code

_____

Telephone Fax

_____

Email address

Diagnostic information

Primary: _____

Secondary: _____

Tertiary: _____

_____

Diagnosed by

Diagnosed date: _____

Please attach diagnostic assessment report completed within last six months. Please also attach a *Letter of Medical Necessity*.

Assessment, treatment information and recommendations:
(completed by board certified behavior analyst/board certified assistant behavior analyst/ licensed provider according to state mandate)

Intake session complete? ___Yes Date_____ (attach notes)
___No

Reason for referral (current risk, presentations, symptoms and purpose of assessment/testing):

_____

_____

_____

_____

What other services and/or supports are in place (e.g., Intellectual and Developmental Disabilities waiver, Serious Emotional Disturbance waiver, other waiver services, physical/occupational/speech therapy, individualized education plan/school-based services, etc.)?

_____

_____

_____

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

https://providers.amerigroup.com/KS

Assessment tools being used (e.g., Assessment of Basic Language and Learning Skills, Verbal Behavior Milestones Assessment and Placement Program, Functional Behavioral Assessment, etc.): _____
_____
_____
_____
_____

Assessment type	Units	CPT code
Consultative clinical and therapeutic services (CCTS)		
Adaptive behavioral treatment for first 30 minutes		0368T
• Each additional 30 minutes		0369T
Family adaptive behavior treatment		0370T
Intensive individual support services (IISS)		
Adaptive behavioral treatment by protocol for first 30 minutes		0364T
• Each additional 30 minutes		0365T

The typical authorization does not exceed 50 hours for CCTS or 25 hours per week for IISS. If you are requesting additional units, please submit documentation to support the medical necessity for the additional hours.

Provider signature: _____ Date: _____