Amerigroup RealSolutions in healthcare

KanCare

Kansas Autism Waiver Outpatient Treatment Request Form

Amerigroup Kansas, Inc.
Telephone: 1-800-454-3730 Fax: 1-800-505-1193

Fill out completely to avoid delays.

Identifying data		
Patient's name:		
Medicaid ID:		Date of birth:
Patient's address:		
City, state:		ZIP code:
Phone number:		
Parent/legal guardian name:		
Parent/legal guardian phone number:		
Autism specialist information		
Provider name:		
Tax ID:	Phone:	Fax:
Autism specialist name/provider number:		Autism specialist NPI:
Name of other autism waiver providers:		
Autism diagnosis		
Vineland II Survey Interview Adaptive Behavior Scales		
Date of assessment:		
Adaptive areas: Communication Daily living skills Socialization Motor skills	Maladaptive areas: Internalizing Externalizing Total	
Criterion-referenced skill-based assessment		
Date of most recent assessment:		
Assessment of Basic Language and Learning Skills – Revised (ABLLS-R) Assessment, Evaluation and Programming System for Infants and Children (AEPS) Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) Other (please specify)		

Patient name: ____

Type of request:

Plan of care (POC): ❑ Annual

If annual, include copy of notice of action from functional eligibility specialist.

❑ Revision

If revised, please provide rationale for change: ____

____

❑ Request for additional children's therapeutic services and supports (CCTS) hours (not part of plan of care)

Treatment goals (If preferable, the individualized behavioral program POC goal sheets can be attached instead of reporting here.)				
Domains	**Measurable goal(s)**	**Date initiated**	**Current progress**	**Date reviewed**
Behavior				
Communication: expressive				
Communication: nonverbal				
Communication: receptive				
Community readiness skills				

Concept formation skills				
Family environment				
Imitation and attending				
Leisure/recreation/ play				
Motor skills				
Self-help skills				
Social interactions				

Patient name: ____

Requested authorization				
T1027 parent support and training				
Start date	End date	Units requested	Provider number	Provider NPI
S9482 family adjustment counseling				
Start date	End date	Units requested	Provider number	Provider NPI
T1005 respite				
Start date	End date	Units requested	Provider number	Provider NPI

Provider's signature: ____

Date: ____

Disclaimer: Authorization indicates that Amerigroup-determined medical necessity has been met for the requested service(s), but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.