Carolina Behavioral Health Alliance
BENEFITS ADMINISTRATION

Request for Evaluation (97151/97152) for ABA Therapy Form

This form is to be used by an evaluating autism provider to request authorization for a complete evaluation and treatment planning of Autism Spectrum Disorder. Individuals must have a diagnosis of Autism Spectrum Disorder (ASD) or Stereotypic Movement Disorder by a qualified provider. Please provide the following information, by fax to 1-888-908-7140, Attention: Utilization Management. Phone number for CBHA: 800-475-7900.

Member Name:				/ /
	First	**Middle**	**Last**	**Date of Birth**

Legal Guardian:	

Member Address:				
	Street	**City**	**State**	**Zip**

Member Plan ID#:	

Diagnosis:		**Date:**	/ /
Severity:			

Diagnosing Clinician:		Credential(s):	
Agency:		Phone #:	

1. Is there a suspicion of a severe/profound intellectual developmental disability? __Yes __No
2. Is the member legally blind and/or deaf? __Yes __No
3. There is a reasonable expectation on the part of the qualified evaluating healthcare professional that the individual's behavior will improve significantly with ABA therapy: __Yes __No (If no, please explain on a separate attachment)

I certify the accuracy and completeness of all information submitted on this form:

Name: _____ Date: _____ Ph: _____

P. O. Box 571137
Winston-Salem, NC 27157-1137
(336) 499-4000 (800) 475-7900