



Early Intensive Behavioral Intervention (EIBI) Services Pre-Authorization Request Form

Type of review: Initial Concurrent

All components of the diagnostic assessment for autism spectrum disorders AND psychological testing, as described in the Blue Cross and Blue Shield of Minnesota Medical Policy X-43, must be completed before EIBI services can be approved. Providing complete information will help expedite this review. Please send a copy of the most recent assessment and testing results with interpretations with this form.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit pre-service prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at www.Availity.com to ensure a timely review.

Providers outside of Minnesota or without electronic access can fax this form and complete clinical records to support the request, to (651) 662-0854.

Member Information	<p>Member ID: _____ Date of birth: _____</p> <p>Member name: _____</p> <p>Member address: _____</p> <p>City/state/zip: _____</p> <p>Member phone: _____</p> <p><i>Please answer the following questions if the patient is age six (6) or above:</i></p> <p>School attended in the past: (check one) <input type="checkbox"/> No <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time</p> <p style="margin-left: 20px;">• (If part-time or full-time) Dates: _____ Hours per day: _____</p> <p>School attending currently: (check one) <input type="checkbox"/> No <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time</p> <p style="margin-left: 20px;">• (If part-time or full-time) Hours per day: _____</p> <p>Indicate coordination plan with educational system: _____</p>
Provider Information	<p>Contact person: _____</p> <p>Phone: _____ Fax: _____</p> <p>Clinic name: _____ Clinic ID #: _____</p> <p>Clinic NPI number: _____</p> <p>Individual provider ID/NPI number: _____</p> <p>Individual provider name: _____ Degree/Lic: _____</p> <p>Provider address: _____</p> <p>City/state/zip: _____</p> <p>Supervising mental health professional name/credentials: _____</p>

List all Diagnosis and ICD-10 codes: _____

List ALL Medications and dosages: _____

Is the member medication compliant? Yes No

List all supplements (vitamins, herbals, etc.): _____

Date ABA therapy started under any provider: _____

Date ABA therapy started with current provider: _____ Number of sessions to date: _____

Date range for authorization request: _____ through _____

Requested number of hours per week: _____ Estimated length of treatment: _____

Parent/guardian authorizes treatment: Yes No

Parent education and support services available: _____

Service Codes with Description	Specify Hours per Week	Units	From Date	To Date

As stated in Medical Policy X-43 for initial requests, please include:

Component	Included? Yes or No	Date of Assessment
Diagnostic assessment within the past 24 months with assessments by Independent Licensed Psychologist or Physician, that includes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<ul style="list-style-type: none"> Assessment of symptoms of Autism Spectrum Disorder (e.g. ADOS; ADI-R) 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Adaptive Behavior Assessment (e.g. Vineland Adaptive Behavior Scales, Adaptive Behavior Assessment System)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical evaluation including neurologic exam	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Functional Behavioral Assessment within the past 12 months completed by BCBA or Licensed Psychologist or Physician	<input type="checkbox"/> Yes <input type="checkbox"/> No	
A treatment plan with all of the following elements: <ul style="list-style-type: none"> Identification and detailed description of targeted behaviors Detailed description of treatment modalities and interventions for each targeted behavior Specific, quantifiable goals that related to deficits or behaviors that pose a significant risk of harm to the patient or others Objective, observable, and quantifiable metrics utilized to measure change toward the specific goal behaviors 	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Treatment Plan	<ul style="list-style-type: none"> • Documentation of adjunctive treatments (e.g. occupational therapy, speech therapy, social skills training, medication services) • Plan for communication and coordination with other providers and agencies • Total number of days per week and hours per day of direct services to the patient and caregivers 		
	Does the treatment plan specify substantive weekly caregiver support and training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	As stated in Medical Policy X-43 for concurrent requests, please include:		
	Component	Included? Yes or No	Date of Assessment
	Does the patient show improvement from baseline in targeted skill deficits and behaviors identified in the approved treatment plan using validated assessments of adaptive functioning (e.g. Vineland, ABAS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Assessment of adaptive functioning and/or functional behavior assessment at least every 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Patient's caregivers demonstrate continued commitment to participate in treatment plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Continued supervision of paraprofessionals by a qualified provider (BCBA, Licensed Psychologist or Physician)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	As stated in the Medical Policy X-43, please include:		
	Does the treatment plan include Parent Training conducted by a BCBA, Psychologist, or Physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the treatment plan include a paraprofessional /Staff Supervision Schedule, with supervision conducted by a BCBA, Psychologist, or Physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the treatment plan include a Discharge Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Treatment Plan	Behavior Reduction Goals - Please note that your graphs must meet BACB guidelines for graphing, as detailed in section C-10 of the BACB: BCBA/BCaBA Task List (5 th edition).	
Please attach a graph for each behavior reduction goal, listing one behavior per graph. Display either per session or weekly or monthly data.		

Discharge Plan	Discharge Plan - Please note that the discharge plan must meet BACB guidelines for discharge, as detailed in Section 8: Discharge, Transition Planning, and Continuity of Care in Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers.	
	Please indicate the discharge plan for this member:	

Signatures	Clinical Supervisor / credentials	Date
	Lead Behavior Therapist / credentials	Date
	Parent/Guardian signature	Date