

## ATTENTION: PLEASE READ

Please review ALL documents and forms carefully prior to completing any of the forms.

Please note that the primary care physician (PCP) is not required to refer member for any of the services outlined in the Treatment Authorization Request (TAR); it is up to the PCP to make the determination based on medical necessity. If you are making a referral for any of the services listed on the form and have pertinent screening forms or medical records, please attach them to the form. Please include the ICD-10 code/diagnosis (possible diagnosis or symptoms) on the forms.

**NOTE:** If making a referral for ABA, CDE, or psychological testing, please DO NOT complete the "Refer To Information" on the TAR form. Our team of coordinators will make the referral and coordinate with our in-network providers as needed.

Please have the parent/caregiver call our team so that we may educate them on the referral process.

If you have questions, please submit your inquiries to [BHTProgram@blueshieldca.com](mailto:BHTProgram@blueshieldca.com) or call (888) 297-1325.

## Behavioral Health Treatment (BHT) Referral Steps and Options

Scenario A	Scenario B	Scenario C	Scenario D
<p>Member or member's family suspects member has Autism Spectrum Disorder</p> <p>You suspect member has Autism Spectrum Disorder</p>	<p>Member has never had a psychological assessment (or it is over 2 years old) and there are behavioral health concerns</p> <p>Member is seeking ABA treatment but has never had a recommendation from a licensed psychologist or recommendation is over 2 years old</p> <p>You are unsure of what specific treatment member may need</p>	<p>You deem BHT to be medically necessary, but are not necessary recommending ABA (either due to lack of supporting documentation or ABA is not clinically indicated)</p> <p>- Check "other" on Treatment Authorization Request form</p>	<p>You have conducted your own assessment, are familiar with ABA, deem that the member can benefit from ABA treatment and have filled out the attached form with the member's family</p> <p>A licensed psychologist has diagnosed member with Autism Spectrum Disorder, you deem that the member can benefit from ABA treatment specifically, and you have filled out the attached form with the member's parent or primary caregiver</p>
<b>NEXT STEP:</b>	<b>NEXT STEP:</b>	<b>NEXT STEP:</b>	<b>NEXT STEP:</b>
Referral for CDE	Referral for Psych Assessment	Referral for Mental Health	Referral for ABA
<p><b>A comprehensive diagnostic evaluation for Autism Spectrum Disorder</b> is administered by a licensed psychologist.</p> <p>The evaluation may include a parent/care-giver interview and testing in the following areas: cognition, development, language, and social interaction. It will either yield a diagnosis of autism or not and will provide recommendations as needed.</p>	<p><b>A psychological assessment</b> is a thorough assessment of an individual administered by a licensed psychologist.</p> <p>The assessment may include normreferenced psychological tests, interviews with significant others, observations &amp; informal assessments. It may yield a diagnosis and recommendations for treatment, if applicable.</p>	<p><b>Mental Health</b> services include all evidence-based services for treatment of mental and/or substance use disorders that may include depression, post-traumatic stress, anxiety disorders, phobias, ADHD, mood disorders and more.</p> <p>Other common behavioral health treatments include, but are not limited to: individual and group counseling, medication, and other supportive services.</p>	<p><b>Applied Behavior Analysis (ABA) treatment</b> is a <i>specific type of behavioral health treatment</i> that addresses socially significant behaviors (e.g., maladaptive behaviors, social interactions, communication, and self-help skills) through the application of behavioral strategies. Treatment typically occurs in the setting these behaviors are desired to occur (e.g., homes, schools, community, etc). ABA was first implemented with individuals with Autism and intellectual disability and empirical research has mostly been concentrated on efficacy with these populations. The first step in starting ABA services is having a BCBA conduct an FBA.</p>

Behavioral Health Treatment phone: (888) 297-1325  
 Behavioral Health Treatment fax: (844) 283-3298



# Service authorization request

URGENT                      ROUTINE                      RETROACTIVE

Patient Information					
Member Name			Primary Language Spoken		
Date of Birth			Require Interpreter	No	Yes
Member Address			City		ZIP
Phone			Gender	Male	Female
Member ID			Medi-Cal	Cal MediConnect	
Refer To Information					
Date of Request		Provider Name		Specialty	
Provider Address			Phone		Fax
Facility Name			Phone		Fax
Service(s) Requested					
Initial Consult		Follow-up Visit(s)		Home Health	Social Services      DME
<b>Diagnostic Evaluation for Autism Spectrum Disorder</b>			<b>Psychological Assessment for:</b>		
<b>Applied Behavioral Analysis (If checked, please submit the ABA Referral Form to establish medical necessity)</b>					
Inpatient Admission		Outpatient Procedure		Other:	
Diagnosis			ICD 10 Code(s)		
Service(s)/Procedure(s)			CPT Code(s)		
Reason for Request					
Prior Treatment and Results					
Relevant Labs/X-rays, etc.					
Health Education (specify)					
Requesting Physician's Name (PLEASE PRINT)					
Physician's Signature			License Number		
Physician's Phone			Fax		
Accident	Yes	No	Where Occurred	Home	Work      Auto      Other:
To Be Completed by Blue Shield of California Promise Health Plan ONLY					
UM Decision Status		APPROVED	MODIFIED	DEFERRED	DENIED
AUTH#			Date approved		Expires on
COMMENTS					
Reviewer's Name			Signature		Date
Member Eligibility as of			PCP Provider ID		
IPA Responsibility		MBHO Responsibility		Date faxed to IPA/MBHO	

**This referral does not guarantee eligibility. Check eligibility prior to rendering service.**

Payment will NOT be made for unauthorized services. All lab and x-rays must be ordered/performed by contracting providers. (Contact Blue Shield Promise UM Department at above number if unsure.)  
 Specialist reports must be sent to PCP promptly.

# Applied Behavioral Analysis referral form

Promise Health Plan

\*This completed form is required before Applied Behavioral Analysis (ABA) services will be authorized. If you are not recommending or prescribing ABA treatment for the patient, this form does not need to be filled out.

<b>This form must be reviewed and signed by an M.D. or Licensed Clinical Psychologist.</b>			
Member First Name		Member Last Name	
Member's Diagnosis		Member ID	
Date of Birth		Provider Who Rendered the Above Diagnosis	
Date of Diagnosis			
Parent/Caregiver Name		Relationship to Member	Primary Phone Number
Date Member Was Last Seen		Duration You Have Treated Member	
<b>Is ABA recommended?</b> Yes    No		Alternate Treatment Recommendation (counseling, speech or play therapy...)	
Does the member have a previous history of receiving ABA services?    Yes    No			
Referring Provider's First and Last Name		Referring Provider's Phone Number	
<b>Signature of Referring Provider</b>	Date	License Type	License Number
<b>ABA Referral Reason</b> Referring M.D. or Licensed Clinical Psychologist must check box(es) below and complete comment section to indicate why member is being referred for ABA services.			
Tantrum Behavior	Deficits in Safety Awareness	Communication Deficits	
Aggression	Deficits in Self-Help Skills	Deficits in Social Interaction	
Self-Injurious Behavior	Skill Acquisition	Restrictive, Repetitive Patterns of Behavior	
Self-Stimulatory Behavior	Property Destruction	Other (Please describe below)	
Elopement	Poor Executive Functioning		
Notes/Comments: (Referral reason(s) must be clearly indicated below)			