

**Indiana ABA Treatment Plan Cover Page**

Please go to [provider express](https://optumpeeraccess.secure.force.com/ABAtreatment/) to complete this form via portal or you my fax this form to 1-877-217-6068 with your treatment plan, or you have the option to call 1-866-830-0325.

*(Note: Text fields will expand as needed. You may copy and paste into fields.)*

|  |  |
| --- | --- |
| **Provider Name** (Last, First): Click here to enter text. | **Provider TIN**: Click here to enter text. |
| **Member Name** (Last, First): Click here to enter text. | **Member ID #**: Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Please list all hours requested per month/week** | | |
| **H0031** (1 hour) | Treatment Planning and Assessment (hrs/month or week) | Click here to enter text. |
| **H0032** (1 hour) | Supervision by licensed clinician or BCBA® (hrs/month or week) | Click here to enter text. |
| **H2012** (1 hour) | Parent Training by BCBA (hrs/month or week) | Click here to enter text. |
| **H2012** (1 hour) | Direct work by BCBA (hrs/month or week) | Click here to enter text. |
| **H2019** (15 min) | Parent training by paraprofessional (hrs/month or week) | Click here to enter text. |
| **H2019** (15 min) | Direct services by paraprofessional (hrs/month or week) | Click here to enter text. |
| **H2014** (15 min) | Group ABA services (hrs/month or week) | Click here to enter text. |

*\*New CPT codes are effective 3/30/20, please attach breakdown requested for these CPT codes. For more information visit* [*www.providerexpress.com*](http://www.providerexpress.com) *> Autism/ABA information*

Proposed Start Date of Authorization/Notification: Click here to enter text.

Proposed End Date of Authorization/Notification: Click here to enter text.

Current Primary DSM-5 Diagnosis and Code Number: Click here to enter text.

Who gave the diagnosis? Click here to enter text.

Date diagnosis was given: Click here to enter text.

Other Medical Conditions: Click here to enter text.

Medications: Click here to enter text.

If this is a concurrent review, is this an increase, decrease or no change in hours requested? Choose an item.

Location of services: School, Home, Community, Facility/Office? Choose an item.

Date ABA services began with this provider: Click here to enter text.

Date ABA services began with any provider: Click here to enter text.

Overall progress summary: No progress, minimum progress, moderate progress or met all goals? Choose an item.

Other services child receives (including school/academic hours): Click here to enter text.

Is there coordination of care with other providers? Note: If yes, please include coordination of care in attached treatment plan. Choose an item.

Does member display high-risk behavioral challenges (aggression, self-injurious behavior)? Choose an item.

What is the severity of communication deficit? Choose an item.

What is the severity of social deficit? Choose an item.

What is the severity of behavior deficits? Choose an item.

What is the severity of destructive, maladaptive behaviors? Choose an item.

How many hours per month are the caregivers involved in either sessions or caregiver training? Choose an item.

How would you rate caregivers in regards to their proficiency with ABA techniques and working with the individual? Choose an item.

For full criteria, please go to [**providerexpress.com**](http://www.providerexpress.com/), click on Clinical Resources > Level of Care Guidelines > IN Intensive Behavioral Therapy (IBT) for Autism.