BlueCross BlueShield of Montana

Applied Behavior Analysis (ABA)

Initial Assessment Request

Submit form at least two weeks before requested start date.
For any questions, call BCBSMT at 855-313-8909 or BCBSMT FEP at 877-885-3751. Fax form to 855-649-9681.

PATIENT INFO

Patient Name _____ **Patient Date of Birth** _____ **Request Submission Date** _____

Subscriber Name _____ **Subscriber ID** _____ **Group** _____

Patient resides in what state? _____ **Services conducted in same state?** ☐ Yes ☐ No If no, what state? _____

DIAGNOSTIC PRACTITIONER INFO

Diagnostic Practitioner Name _____ **NPI** _____

Telephone _____ **Fax** _____ **Contact Name** _____

Diagnostic Practitioner Type, if PCP: ☐ Family Practice ☐ Internal Medicine ☐ Pediatrics

Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider: ☐ Developmental Behavioral Pediatrics ☐ Neurodevelopmental Pediatrics

☐ Child Neurology ☐ Adult or Child Psychiatry ☐ Licensed Clinical Psychology ☐ Other (specify) _____

Primary Diagnosis Code _____ **Secondary Diagnosis Code** _____

Current diagnostic required not older than 36 months.

Initial Evaluation Date _____ /_____ /_____ **Most Recent Evaluation Date** _____ /_____ /_____

PROVIDER INFO

Rendering Qualified Healthcare Provider (QHP)* Name _____

**Fill in the Rendering QHP who is directly providing treatment.*

NPI _____ **Email** _____

Telephone *(Please provide a number with confidential voicemail.)* _____ **ext** _____

Master's/PhD level clinician/state-recognized professional credential or certification _____

State _____ **License/Cert#** _____

Practice Name _____

NPI _____ **Fax** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Practice Contact Name _____ **Telephone** _____ **ext** _____

Billing Contact Name _____ **Telephone** _____ **ext** _____

PROVIDER TREATMENT REQUEST

Assessment Request Start Date _____ /_____ /_____ **to End Date** _____ /_____ /_____

ABA Assessment Code Request (Total Units for Assessment Period; 1 Unit = 15 minutes)	**97151** QHP	**97152** Technician

Additional Code(s) Request and Reason

This form must be received **within 30 days** *of the start date of your assessment with the member. After that date, claims should be submitted through your normal process and you will receive instructions on how to proceed.*

CERTIFICATION OF PROVIDER QUALIFICATIONS

Rendering QHP Signature _____ **Date** _____ /_____ /_____

Rendering QHP Printed Name _____ **Practice Name** _____

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