

# Request for Authorization: Autism Spectrum Disorder Testing

Anthem Blue Cross and Blue Shield Medicaid | Ohio Medicaid Managed Care

**Instructions:** Please complete and submit this form online through Availity Essentials at <https://Availity.com> or the link provided at <https://anthem.com/oh/provider> prior to rendering services.

Member information	
First name:	Last name:
DOB:	Member ID number:

Provider information	
First name:	Last name:
Name of professional administering testing (If different than provider named above)	
First name:	Last name:
Phone:	Fax:
NPI:	Tax ID:
Address:	
Email:	
Billing facility/group name:	
Billing facility/group NPI:	Billing facility/group tax ID:
Billing facility/group address:	

Formal psychological testing is not clinically indicated for routine screening or assessment of behavioral health disorders. Psychological testing is not indicated for the administration of brief behavior screening measures and inventories. **Such screening measures and inventories are an expected part of a routine and complete diagnostic process.** Other than in exceptional cases, the psychologist should complete a diagnostic interview and relevant screening measures prior to submission of requests for psychological testing authorization. Requests for placement purposes, disability evaluations, and forensic purposes are not covered benefits. Refer requests for educational testing or assessment of learning disabilities to the public school system. **This form is for autism spectrum disorder**

**testing requests only.** You must complete requests for psychological or neuropsychological testing on their requisite forms.

### Clinical assessment

Indicate which of the following assessments were completed.	
<input type="checkbox"/> Psychiatric and medical history	<input type="checkbox"/> Clinical interview with patient
<input type="checkbox"/> Interview with family members	<input type="checkbox"/> Direct observation of patient
<input type="checkbox"/> Evaluation by speech-language pathologist	<input type="checkbox"/> Structured developmental and social history
<input type="checkbox"/> Review of academic records/IEP	<input type="checkbox"/> Brief inventories and/or screening measures
<input type="checkbox"/> Family history pertinent to testing request	<input type="checkbox"/> Consultation with school/other important persons
<input type="checkbox"/> Developmental screening evaluation by a physician or psychologist	
<input type="checkbox"/> Medical evaluation (complete medical history and physical examination with hearing and vision screening)	
<b>Date of diagnostic interview:</b>	
Please attach any relevant clinical or medical records that support your testing request when submitting this form.	

### Screening measures

Indicate which screeners have been administered prior to submitting this testing request as part of your clinical assessment:			
<input type="checkbox"/> ASRS	<input type="checkbox"/> SCQ	<input type="checkbox"/> SRS	<input type="checkbox"/> MCHAT
<input type="checkbox"/> CARS	<input type="checkbox"/> GARS	<input type="checkbox"/> GADS	<input type="checkbox"/> Other:
Screener results:			

### Treatment history

Provide the following treatment history information.

	How often does the member	How long has the member	Is member still in treatment?	Have symptoms improved?
--	---------------------------	-------------------------	-------------------------------	-------------------------

	receive services?	been in treatment?		
Mental health/behavioral therapy:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	___ days ___ weeks ___ months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication management:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	___ days ___ weeks ___ months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech therapy:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	___ days ___ weeks ___ months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational therapy:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	___ days ___ weeks ___ months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Early childhood intervention:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	___ days ___ weeks ___ months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Additional information that supports the request for ASD testing:**

**Previous ASD testing** — Provide dates, results, and why retesting is requested.

Test date	Test type	Results	Reason for retest request

**DSM-5/ICD-10 diagnosis under evaluation**

Provide the following information for any diagnosis being evaluated.

Code(s)	Status	
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional
	<input type="checkbox"/> Current	<input type="checkbox"/> Provisional

### Rationale for testing

What diagnostic or clinical questions remain unanswered by the previously administered clinical interview, review of records, or screening measures?

How will the results of testing impact the course of treatment?

Is this a request to access ABA services?  Yes  No

### Psychological tests and services requested

Provide the following information:

- For tests with multiple versions, specify which version.
- If you are administering selected subtests, indicate which subtests.
- Attach a separate sheet to the submission, if necessary.

CPT® code(s)	Unit(s)	Evaluation services/test names to be administered
<input type="checkbox"/> 96130 (one unit maximum)		
<input type="checkbox"/> 96131		
<input type="checkbox"/> 96136 (one unit maximum)		
<input type="checkbox"/> 96137		

CPT® code(s)	Unit(s)	Evaluation services/test names to be administered	
<input type="checkbox"/> 96138 (one unit maximum)			
<input type="checkbox"/> 96139			
<b>Total units requested:</b>		<b>Total time requested:</b>	

Provider signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled in your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.