Request for Authorization: Autism Spectrum Disorder Testing

California | Anthem Blue Cross | Medi-Cal Managed Care (Medi-Cal)

Instructions: Please complete and submit this form online through Availity Essentials at https://Availity.com or the link provided at https://providers.anthem.com/ca 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:	

Are services being rendered in person or via telehealth? ☐ In-person ☐ Telehealth	
Servicing 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

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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.	
☐ Psychiatric and medical history	☐ Clinical interview with patient
☐ Interview with family members	☐ Direct observation of patient
☐ Evaluation by speech-language pathologist	☐ Structured developmental and social history
☐ Review of academic records/IEP	☐ Brief inventories and/or screening measures
☐ Family history pertinent to testing request	☐ Consultation with school/other important persons
☐ Developmental screening evaluation by a physician or psychologist	
☐ Medical evaluation (complete medical history and physical examination with hearing and vision screening)	
Date of diagnostic interview:	
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:			
☐ ASRS	☐ SCQ	☐ SRS	☐ MCHAT
☐ CARS	☐ GARS	☐ GADS	☐ Other:
Screener results:			

Treatment history

Provide the following treatment history information.

	How often does the member receive services?	How long has the member been in treatment?	Is member still in treatment?	Have symptoms improved?
Mental health/behavioral therapy:	☐ Weekly ☐ Bi-weekly ☐ Monthly	____days ____weeks ____months	☐ Yes ☐ No	☐ Yes ☐ No
Medication management:	☐ Weekly ☐ Bi-weekly ☐ Monthly	____days ____weeks ____months	☐ Yes ☐ No	☐ Yes ☐ No
Speech therapy:	☐ Weekly ☐ Bi-weekly ☐ Monthly	____days ____weeks ____months	☐ Yes ☐ No	☐ Yes ☐ No
Occupational therapy:	☐ Weekly ☐ Bi-weekly ☐ Monthly	____days ____weeks ____months	☐ Yes ☐ No	☐ Yes ☐ No
Early childhood intervention:	☐ Weekly ☐ Bi-weekly ☐ Monthly	____days ____weeks ____months	☐ Yes ☐ No	☐ Yes ☐ 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	
	☐ Current	☐ Provisional
	☐ Current	☐ Provisional
	☐ Current	☐ Provisional
	☐ Current	☐ Provisional
	☐ Current	☐ Provisional
	☐ Current	☐ 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	
☐ 96130 (one unit maximum)			
☐ 96131			
☐ 96136 (one unit maximum)			
☐ 96137			
☐ 96138 (one unit maximum)			
☐ 96139			
Total units requested:		Total time requested:	

Provider signature: _____ Date: _____

This form can also be submitted via fax to [855-473-7902] prior to rendering services.

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.