

Behavioral Health Treatment/Applied Behavioral Analysis/Autism Services Recommendation Form

This form is designed to meet the Department of Health Care Services (DHCS) requirement for a medical necessity recommendation for behavioral health treatment (BHT) or applied behavioral analysis (ABA) services. A physician or licensed psychologist should complete this form.

Give this completed form to the family or the identified BHT/ABA provider. The rendering BHT/ABA provider will submit this form with a preauthorization request.

Member information
Date of birth:
Member ID: Preferred language: Evaluating provider information Provider name: License number: Street address: City: Office number: Fax: Evaluation/assessment details Behavioral health diagnoses: Secondary: Primary: Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): Self-injury Aggression Biographic Aggression
Preferred language: Evaluating provider information Provider name: License number: Street address: City: Office number: Evaluation/assessment details Behavioral health diagnoses: Secondary: Primary: Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): Self-injury Aggression
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Office number: Fax: Evaluation/assessment details Behavioral health diagnoses: Secondary: Primary: Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): Self-injury Aggression Elopement
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Secondary: Primary: Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): Self-injury Aggression Elopement
Primary: Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): Self-injury Aggression Elopement
Medical diagnoses: Summary of identified behavioral excesses and/or deficits (select all that apply): □ Self-injury □ Aggression □ Elopement
Summary of identified behavioral excesses and/or deficits (select all that apply): □ Self-injury □ Aggression □ Elopement
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☐ Speech delay ☐ Sensory-seeking behaviors ☐ Echolalia
□ Nonverbal □ Rigid adherence to routines □ Repetitive behaviors
☐ Food selectivity/rigidity ☐ Lacks social skills ☐ Lacks ADL skills
Pood selectivity/ligidity Lacks social skills Lacks ADL skills
Other issues/concerns:
Is BHT/ABA treatment assessment recommended? ☐ Yes ☐ No
Has the family/caregiver(s) chosen a BHT/ABA agency? ☐ Yes ☐ No
If no, refer the family to an Anthem Blue Cross case management program by faxing a copy of this form to
1-855-473-7902 or by emailing a copy of this form to bhcmreferrals@anthem.com. Ensure the member has the
original copy of the form. Please indicate specific case management need below:
For providers with questions, contact the intake line at 1-888-831-2246 option 1 , option 2 . For members with
additional questions, contact Customer Service at 1-888-285-7801 for Los Angeles County or 1-800-407-4627 for
all other counties.
Provider signature: Date:

https://mediproviders.anthem.com/ca

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