



Submit form at least two weeks before requested start date. For any questions, call BCBSTX at 866-355-5999. Fax form to 877-361-7646.

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?

DIAGNOSTIC PRACTITIONER INFO

Diagnostic Practitioner Name, NPI, Telephone, Fax, Contact Name, Diagnostic Practitioner Type, if PCP, Diagnostic Practitioner Type, if Specialized ASD-Diagnosing Provider, Primary Diagnosis Code, Secondary Diagnosis Code, Initial Evaluation Date, Most Recent Evaluation Date

PROVIDER INFO

Rendering Qualified Healthcare Provider (QHP)* Name, NPI, Email, Telephone, 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

Table with 2 columns: 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

