ABA Assessment Request Form

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.

Patient Information:

Patient's Last Name/First Name: _____

Patient's DOB: _____Subscriber ID #: _____

Provider Information:

_____

Name of Provider Federal Tax ID# Licensure/Certification

_____

Street Address City State Zip

_____

Telephone # Email Address Fax #

Assessment, Treatment Information and Recommendations:

Date of Intake Session: _____

Case History and Purpose of Assessment/Testing:

_____

_____

Diagnosis:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medical Diagnosis: _____

List all Assessments/Testing Requested (i.e., FBA, VB-MAPP, etc.):

_____

_____

HCPC Code	Service	Hours
H0031 (1 hour)	Assessment & Treatment Planning by BCBA or licensed ABA provider	

_____ _____

Signature of Provider Date

Submit the completed ABA Assessment Request Form to the attention of the Care Advocate at the address or fax number that appears on the letter that came with this form.