HSCSN PROVIDER REQUEST FOR ABA EVALUATION

THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

This form must be completed by a treating practitioner. Fax this form and supporting documents to HSCSN Utilization Management at **Fax: 202-721-7190** or email: **UM@hschealth.org.**
IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.

DATE OF REQUEST:	
PROVIDER	**MEMBER**
Ordering Provider (MD or NP):	**Member Name:**
Provider NPI #:	**Member ID:** **DOB:**
Provider Phone #: **Fax #:**	**Primary Diagnosis:**
Provider Email:	**Other Diagnoses:**

What are the child's current behavioral problems to be addressed with ABA therapy?

☐ Aggression: verbal, physical, injurious or destructive behavior such as biting, kicking, punching, destruction of property, self-injurious behavior such as head banging, pulling out hair, burning, branding or rubbing skin to produce sores or scars

☐ Extreme Impulsivity: includes daredevil behavior that involves risk-taking that could be a danger to self and/or Elopement Behaviors

☐ Overt Agitation: child having problems managing the following: vocalizations, upper extremity movements, lower extremities; frustration tolerance; stereotyped/repetitive behaviors

☐ Non-compliant behavior: unwilling to follow the simplest of rules; requires constant re-direction; requires constant supervision

☐ Emotional Instability: angry outbursts with increasing frequency and intensity, mood lability

Does the child's behavior interfere with their day to day functioning?

☐ Home ☐ School ☐ Community

For children 3 years, 11 months and younger, please provide clinical information about the child's engagement with early intervention services by detailing services they receive, or explaining why they do not receive early intervention services. If available, attach a copy of the IFSP, which supports whole person care and coordination of clinical/service needs.

For children 4 years and older, in evidence of whole person care and coordination of clinical/service needs, please attach the IEP (if available) or provide an explanation as to why it is not included.

Please provide any additional clinical information needed to support the medical necessity for the request:

Signature of requesting provider: Date:

Printed Name: