Health Services for Children with Special Needs, Inc. (HSCSN)

UM Medical Necessity Documentation for ABA Services

This form must be completed by the ABA Provider that performed the evaluation for ABA. Please attach copies of reports and materials that will be helpful in reviewing this request. Fax this form and supporting documents to the Utilization Management department at **202-721-7190**.

Date :		
Enrollee Name:	Enrollee ID Number:	DOB: Circle: ○ M ○ F
Name of ABA Provider:		Phone/Fax/Email:

Primary Diagnosis:	
Co-occurring psychiatric diagnoses:	
Co-occurring medical diagnoses:	

I. Behavioral problems to be addressed with ABA therapy (one or more):

- ☐ 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.

II. Behavioral interference (one): ☐ Home ☐ School ☐ Community

III. Potential for improvement (required): ☐ Yes ☐ No (Explain below)

_____

IV. Support System (both): ☐ Parent/caregiver unable to manage intensity of symptoms
☐ Parent/caregiver willing to participate and learn ABA strategies

V. Days and number of hours per week of ABA services requested. Please provide justification.

_____

_____

VI. Expected duration of treatment: _____

ABA Provider Signature:_____ Date:_____

HSCSN use only:

Does the member meet medical necessity (ASD diagnosis and I-V above)? ☐ Yes ☐ No

Requested hours of treatment is 10 or less per week: ☐ Yes ☐ No Hours authorized:_____

When the requested hours are greater than 10 per week, complete the Psychologist/Physician Review Form.

Signature of UM staff: _____ Date:_____