HSCSN REQUEST FOR ABA TELEHEALTH

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**
Requesting Provider (Supervising BCBA):	**Member Name:**
Provider NPI #:	**Member ID:** **DOB:**
Provider Phone #: **Fax #:**	**Primary Diagnosis:**
Provider Email:	**Other Diagnoses:**
Logistics Information	
What is the telehealth communication system that will be used?	
How will privacy be maintained?	
Who will partner in physically working with the member?	
Clinical Information	
What existing treatment goals will be transferred to telehealth?	
How will these treatment goals be targeted through telehealth?	
How many hours per week of telehealth is requested to address the noted treatment goals?	

Signature of requesting provider: Date:

Printed Name with credentials: