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 age 4 and above, please attach the IEP or provide an explanation as to why it is not included.

Please provide any other comments:

Signature of requesting provider: Date:

Printed Name:

HSCSN use only:

ABA Evaluation authorized: ☐ Yes ☐ No

Signature of UM staff: _____ Date: _____