Telehealth Request Form

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**](mailto:UM@hschealth.org). **IMPORTANT TO NOTE: This request will not be processed unless all of the items below are completed.**

|  |  |
| --- | --- |
| **DATE OF REQUEST:** Click here to enter a date. | |
| **PROVIDER** | **ENROLLEE** |
| **Requesting Provider (ABA providers must include Supervising BCBA):**  Click to enter text. | **Enrollee Name:** Click to enter text. |
| **Provider NPI #:** Click to enter text. | **Enrollee ID:** Click to enter text.  **DOB:** Click to enter text. |
| **Provider Phone #:** Click to enter text.  **Fax #:** Click to enter text. | **Primary Diagnosis:** Click to enter text. |
| **Provider Email:** Click to enter text. | **Other Diagnoses:** Click to enter text. |
| ***Logistics Information*** Click to enter text. | |
| What is the telehealth communication system that will be used? | Click to enter text. |
| How will privacy be maintained? | Click to enter text. |
| Who will partner in physically working with the member? | Click to enter text. |
| ***Clinical Information*** | |
| What existing treatment goals will be transferred to telehealth? | Click to enter text. |
| How will these treatment goals be targeted through telehealth? | Click to enter text. |
| ***ABA Providers Only*** How many hours per week of telehealth is requested to address the noted treatment goals? | Click to enter text. |

Signature of requesting provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name with credentials: Click to enter text.