Referral for Applied Behavior Analysis (ABA)

BlueCare℠/TennCare*Select*/CoverKids

Please fax to the appropriate precertification number: **BlueCare/TennCare*Select*/CoverKids — 1-800-292-5311**

Please do not use this form if you're an ABA provider or there's already an identified ABA provider for your patient. If you're an ABA provider, please complete the Assessment, Initiation and Continuation Request Form.

Please note ABA referrals must accompany a provider's order for ABA services to initiate a provider search.

Member Information

Member Name: ______________________________ Phone: ______________

Member ID: ______________________________ DOB: ______________

Street Address: ____

City: ______________________________ State: ______ Zip: ______________

Guardian Information

Guardian's Name: ______________________________ Phone: ______________

Street Address: ____

City: ______________________________ State: ______ Zip: ______________

By checking this box, I attest that the member/parent/guardian has given verbal or written permission to submit this ABA referral on their behalf and that BlueCare will be contacting ABA providers to initiate the referral process. (If this has not been done, please complete this step prior to submitting the referral)

Diagnostic Information

Date when member initiated request for this service: ______________________

Pertinent Diagnoses: (Autism, Intellectual Disability, Traumatic Brain Injury)

____

Secondary Diagnoses: ____

Previous and Current Services *(e.g. psych meds, prior ABA services, outpatient therapies, psych acute, respite, etc. including dates of service and provider)*

Please Note: If no treatment attempts are documented, then the behaviors documented below must present a health/safety

Diagnostic Information (Continued)

risk to self/others (i.e. injuries requiring medical attention or imminent risk, such as eloping in traffic)

Referral behaviors occurring within the past 1-2 months documenting **specific examples** and severity level
(e.g. Self-injurious behavior like headbanging that leaves bruises; eloping into traffic; physical aggression like biting that leads to bleeding; injuries resulting from behaviors; etc.)

Additional Information:

Completion Date: ____________________

Ordering Clinician Name and Credentials:

____ Phone _________________________

Completed By: ____

Email: ____

This ABA referral form must be submitted with a compliant order to be processed.