



# Referral for Applied Behavior Analysis (ABA)

- BlueAdvantage (PPO)<sup>SM</sup>
- BlueCare<sup>SM</sup>
- BlueCare Plus Tennessee
- Check here if this member has a FIDE plan.
- CoverKids
- TennCareSelect

Please fax to the appropriate precertification number:

- BlueAdvantage — 1-888-535-5243**
- BlueCare / TennCareSelect / CoverKids — 1-800-292-5311**
- BlueCare Plus Tennessee — 1-866-325-6694**

Please don't 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 BlueCross BlueShield of Tennessee 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)

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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 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.