Behavioral Health Treatment phone: (888) 297-1325
Behavioral Health Treatment fax: (844) 283-3298

blue california
Promise Health Plan

Applied Behavioral Analysis referral form

*Applied Behavioral (ABA) services REQUIRE prior authorization.
This completed recommendation form is required before ABA services will be authorized.

SECTION 1 This form must be completed by an M.D. or Licensed Clinical Psychologist within the last 12 months.

Member First Name	Member Last Name	Member ID
Language		Date of Birth
Primary Diagnosis		
Secondary Diagnosis		
Parent/Caregiver Name	Relationship to Member	Primary Phone Number

Date Member Was Last Seen	Duration You Have Treated Member
Is ABA recommended? Yes No	Alternate Treatment Recommendation
Does the member have a previous history of receiving ABA services? Yes No	
Referring Provider's First and Last Name	Referring Provider's Phone Number

Signature of Referring Provider	Date	License Type	License Number

ABA Referral Reason

Referring M.D. or Licensed Clinical Psychologist must check box(es) below and complete comment section to indicate why member is being referred for ABA services.

Tantrum Behavior	Deficits in Safety Awareness	Communication Deficits
Aggression	Deficits in Self-Help Skills	Deficits in Social Interaction
Self-Injurious Behavior	Skill Acquisition	Restrictive, Repetitive Patterns of Behavior
Self-Stimulatory Behavior	Property Destruction	
Elopement	Poor Executive Functioning	Other (Please describe below)

Notes/Comments: (Referral reason(s) must be clearly indicated below)

(See parent/caregiver section on next page.)

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association L52000-W-PHP (1/20)

Section 2 To Be Completed by the Parent/Caregiver		
Does your child have a current Individualized Education Plan (IEP) at school? Yes No		
If yes, what services does your child received at school? ST OT PT APE VI O&M		
Behavioral Aid Classroom Aid 504 Plan Other:		
How long has your child been receiving services at school?		
Has your child ever received services through Regional Center? Yes No		
If yes, what services were/are being received at Regional Center? ST OT PT VI		
Behavioral Respite Respite Global Development Infant Stimulation		
Other:		
When did your child start receiving services through the Regional Center?		
Has your child been referred for Mental Health Services? Yes No		
If yes, what date(s) did they start and/or stop services?	Start	Stop
If no, would you like a referral for Mental Health Services? Yes No		
Please list concerns you hope will be addressed through Applied Behavioral Analysis:		
Relationship to Child	Date	
Parent/Caregiver Printed Name	Parent/Caregiver Signature	

OFFICE STAFF

Please send completed form to:

Fax: (844) 283-3298

Email: BHTProgram@blueshieldca.com

QUESTIONS?

Phone: (888) 297-1325