Applied Behavior Analysis (ABA) Network Exception Request for Initial Assessment

EVERNORTH℠

CLEAR FORM

Please only fill out the attached form if requesting a network exception for an initial ABA Assessment. Please note, if you are not requesting a network exception, no authorization is needed for ABA assessment services. This form should be completed by a provider who has a thorough knowledge of the Evernorth patient's current clinical presentation and treatment history.

Please note: The information contained in this form may be released to the patient or the patient's representative.

Autism Information and Resources

TIPS FOR COMPLETING THIS FORM:

- Our regular business hours are Monday - Friday, from 8:30 am - 5:00 pm Central Time. You can reach us at 1.877.279.7603 for any issues with submitting your request.
- To help expedite this request, please complete sections as **specifically** and as **clearly** as possible. Omissions, generalities, and illegibility may result in this request being returned for additional information or clarification
- Typed responses are preferred. If completing by hand, please use blue or black ink and print legibly.

Please save this form to your computer, complete & save the form using Adobe Acrobat Reader DC, then email it to:
ABA@Evernorth.com* **(preferred)** or fax 1.860.687.9230.

* Please note that Evernorth assumes no responsibility for the protection of electronically transmitted information prior to its actual receipt of that information. It is your responsibility to take any steps necessary to protect the email or documents prior to receipt by Evernorth.

All fields are required.

Patient Name:	**Patient ID:**	**Date of Birth:**
Home Address:		
Patient/Caregiver contact information:		
Representative to contact with authorization information:	**Phone Number:** ( ) **Ext:**	
Is Voicemail confidential? ☐ **Yes** ☐ **No**	**Email Address:**	
Representative to contact for clinical questions or concerns:	**Phone Number:** ( ) **Ext:**	
Is Voicemail confidential? ☐ Yes ☐ No	**Email Address:**	

Network exception rationale
Please describe why any clinical treatment specialties are clinically relevant for this patient and would be uniquely available from this provider as opposed to another clinician in our existing network.

Place of Service: ☐ **Clinic** ☐ **Home** ☐ **School** ☐ **Community** ☐ **Other** _____

Name of Provider Performing the ABA Assessment:	Tax ID:

Please check what applies. The provider performing the ABA assessment is credentialed or licensed as:

☐ BCBA ☐ BCBA-D ☐ LBA ☐ Licensed Psychologist ☐ Other Licensed (Please specify)

Clinic Name:

Clinic/Practice Address:

Is this patient diagnosed with Autism Spectrum Disorder (ASD)? ☐ Yes ☐ No

Date of most current diagnostic evaluation and evaluator's name/credentials:

Is the above evaluator an independently Licensed Psychologist, Licensed Physicians (MD/DO), LCSW-C, Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, or independently licensed provider who can give a clinical diagnosis.

☐ Yes ☐ No

If no, please further define credentials:

Requested start date of assessment authorization: _____

Assessment Hours

Code	Amount	Hours or Units
97151		
97152		
0362T		

Name of the Standardized Assessment Tool(s) being used (Please refer to Autism Resource link at top of form)

Supervisor's Signature/E-Signature: _____

Date: _____

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