BlueLink TPA

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Pre-Certification/Pre-Authorization Request Form Early Intensive Behavioral Intervention (EIBI) Services

Patient / Provider Information

<table>
<tr><td colspan="2">Patient name:</td><td colspan="2">Provider name:</td><td>Degree/License type:</td></tr>
<tr><td colspan="2">Patient address:</td><td colspan="2">Type of review:
☐ Initial ☐ Concurrent</td><td>Provider address:</td></tr>
<tr><td colspan="2">Subscriber name:</td><td colspan="2">Clinic name:</td><td>Clinic ID (if applicable):</td></tr>
<tr><td>Group #:</td><td colspan="2">Provider #:</td><td>NPI:</td><td>Provider phone:</td></tr>
<tr><td colspan="2">Member ID:</td><td colspan="2">Patient DOB:</td><td>Provider fax:</td></tr>
<tr><td colspan="3">**Axis I**:

Axis III:

Axis V: (GAF) Current</td><td colspan="2">**Axis II:**

Axis IV:

Highest in last 12 months</td></tr>
</table>

Treatment Information

<table>
<tr><td colspan="4">Have the components of the diagnostic assessment for autism spectrum disorders, as described in Medical Policy X-43, been completed? Yes ☐ No ☐</td></tr>
<tr><td>**Date psychological testing performed**</td><td>**Testing Provider's Name**</td><td colspan="2">**Name of psychological tests performed**
(Please send a copy of the most recent testing results/interpretations with the service request)</td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td></td><td colspan="2"></td></tr>
<tr><td colspan="3">Planned start date or date therapy started:</td><td>Number of sessions to date:</td></tr>
<tr><td colspan="3">Requested number of hours per week:</td><td>Dates requested: from to

Estimated length of treatment:</td></tr>
<tr><td colspan="3">Supervising mental health professional:</td><td>Lead behavior therapist:</td></tr>
<tr><td colspan="4">Multi-disciplinary Team Members & credentials:</td></tr>
<tr><td colspan="4">Parent/guardian authorizes treatment: Yes ☐ No ☐
Parent education and support services available:</td></tr>
</table>

Education Information *Please answer these questions if the patient is age six (6) or above*

School attended (hours per day):
Indicate coordination plan with educational system:

Fax form to: (651)662-0854 or mail form to:
Behavioral Health, P.O. Box 64668, St Paul, MN 55164-0668

Treatment Plan (*Sample*)

GOAL #1

Date	**Description of Target Symptom/Behavior**	**Treatment Intervention**	**Treatment Goal**	**Progress Update**	**Projected Date of Completion**
Initial Request	Include objective baseline measures for each target symptom/behavior in terms of frequency, intensity and duration.	Include specific methods involved and number of treatment hours in terms of frequency and duration.	Targeted outcome of the treatment intervention.		Estimated date when patient should be able to complete the treatment goal.
First Review Date (6 months)				Document progress towards goals. Include objective measures used for determining progress. Indicate if goal has been met or suspended.	
Second Review Date (12 months)				Document progress towards goals. Include objective measures used for determining progress. Indicate if goal has been met or suspended.	

The Treatment plan section could go on to include as many goals as the provider wishes to identify and work on.

✓ **For prompt processing of your request please submit the patient's most recent treatment plan and complete ALL fields on the authorization form.**

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Treatment Plan

GOAL #   :

Date	**Description of Target Symptom/Behavior**	**Treatment Intervention**	**Treatment Goal**	**Progress Update**	**Projected Date of Completion**
Initial Request					
First Review Date (6 months)					
Second Review Date (12 months)					

Please make additional copies of this page for subsequent treatment goals.

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Discharge Planning

Signatures

_______________________________ _______________
Clinical Supervisor / credentials Date

_______________________________ _______________
Lead Behavior Therapist/credentials Date

_______________________________ _______________
Parent/Guardian signature Date

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