Diagnostic Evaluation Form (Medi-Cal)

Completed by Physician, Pediatrician, Neurologist, or Licensed Clinical Psychologist (MD/DO/PhD/PsyD)

Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations

Patient Information:

Patient's Last Name/First Name: _____

Patient's DOB: _____ Subscriber ID #: _____

Provider Information:

Name of Provider: _____ License/Certification/Fed Tax ID #: _____

Street Address: _____ City/State/Zip: _____

Telephone #: _____ Fax #: _____

Evaluation/Assessment Information:

Date of Evaluation/Assessment: _____

1. **Summary of Identified Behavioral Excesses and Deficits:**

☐ Speech Delay	☐ Poor Eye Contact	☐ Low Social Response
☐ Low Peer Interaction	☐ Repetitive Behaviors	☐ Hyperactivity
☐ Preoccupation of Interests	☐ Stereotypic Movement	☐ Echolalia
☐ Self-Injury	☐ Aggression	☐ Elopement

2. **Is BHT/ABA Treatment Assessment Recommended:** (yes/no) _____

3. **Behavioral Health Diagnosis:**
   Primary Code: _____
   Secondary Code: _____

4. **Medical Diagnosis:** _____
   Describe any medical condition that could be causing or contributing to behavioral excesses or deficits described above: _____
   _____
   _____

Signature of Provider: _____ Date: _____

*Return Completed Diagnostic Evaluation Form to:

Email:
care.managers@beaconhealthoptions.com

Fax:
800-321-1776