ABA/BHT Referral Form (Medi-Cal)

Must be completed by Licensed Physician, Surgeon, or Psychologist

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

ALL SECTIONS MUST BE COMPLETED FOR SUBMISSION

Patient Information:

Patient's Last Name/First Name: ______________________________

Patient's DOB: ______________________ Subscriber ID #: ______________________

Diagnosis if available (*not required*): ______________________________

Patient is: Under 21 years of age? ____ **Yes** ____ **No** Medically stable? ___ **Yes** ___ **No**

Does the patient need 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities? ___**Yes** ___**No**

Provider Information:

Name of Provider: ______________________ License/Certification/Fed Tax ID #: ___________

Street Address: ______________________________ City/State/Zip: ____________________

Telephone #: ______________________ Fax #: ______________________________

Presenting Behavioral Concerns:

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

Clinical Information

1. Is BHT/ABA Treatment Assessment Recommended? ___ **Yes** ___ **No**
2. Has family/caregiver chosen a BHT/ABA Provider? ___**Yes** ___ **No**

   If yes, ABA/BHT Provider Name: ______________________________

Signature of Provider: ______________________________ Date: ______________

*Return Completed ABA/BHT Referral Form to:

Email: ASGCare.Managers@carelon.com **Fax:** 877-321-1776