PASSPORT ADVANTAGE (HMO SNP)

Outpatient Treatment Review: Applied Behavior Analysis

Phone: 1-866-816-1722

PATIENT			
Name:			
ID:	DOB:		
Address:			
City:	State:	Zip:	
PROVIDER			
Individual Provider:	ID:		
Address:			
City:	State:	Zip:	
Phone:	Fax:		

COORDINATION OF CARE	Yes	No	N/A
Parent/Caregiver is participating in treatment:	❑	❑	❑
I have communicated with patient's PCP or specialist:	❑	❑	❑
I have communicated with patient's psychiatrist or therapist:	❑	❑	❑

DSM DIAGNOSIS numeric + description:
Axis I
Axis II
Axis III

PSYCHOTROPIC MEDICATIONS			
Prescribed by:	❑ PCP	❑ Psychiatrist	❑ APRN
1.			
2.			
3.			
4.			
If affective or psychotic disorder is present and no medications are prescribed, please explain:			

RISK ASSESSMENT				
❑ Suicidal	❑ Ideation	❑ Planned	❑ Imminent Intent	❑ History of self-harming behavior
❑ Homicidal	❑ Ideation	❑ Planned	❑ Imminent Intent	❑ History of behavior harming other

SYMPTOMS - if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
Anxiety	❑	❑	❑	❑	Inattention	❑	❑	❑	❑
Depression	❑	❑	❑	❑	Obsessions	❑	❑	❑	❑
Hyperactivity	❑	❑	❑	❑	Sleep Disturbance	❑	❑	❑	❑

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BEHAVIORS TARGETED FOR REDUCTION — if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
Self-injury	❑	❑	❑	❑	Phys. Aggression	❑	❑	❑	❑
Prop. Destruct.	❑	❑	❑	❑	Verbal Aggression	❑	❑	❑	❑
Threat Making	❑	❑	❑	❑	Non-Compliance	❑	❑	❑	❑
Tantrums	❑	❑	❑	❑	Stereotypy	❑	❑	❑	❑
Elopement	❑	❑	❑	❑	Toileting Issues	❑	❑	❑	❑
Inapp. Touch	❑	❑	❑	❑	Other: _____________	❑	❑	❑	❑

FUNCTIONAL IMPAIRMENT – if present, check degree or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
ADLSs	❑	❑	❑	❑	Physical Health	❑	❑	❑	❑
Family/Relationships	❑	❑	❑	❑	Work/School	❑	❑	❑	❑
Social Skills	❑	❑	❑	❑	Substance Abuse	❑	❑	❑	❑
Functional	❑	❑	❑	❑	Other: _____________	❑	❑	❑	❑
Communication	❑	❑	❑	❑					

DEFINITION OF SUCCESSFUL TREATMENT (See attached Progress Report for detailed outcomes)

Desired observable outcome #1:

Desired observable outcome #2:

Desired observable outcome #3:

Desired observable outcome #4:

LEVEL OF IMPROVEMENT TO DATE

Sessions provided to date: ___________________________

❑ Minor ❑ Moderate ❑ Major ❑ No progress to date ❑ Maintenance tx of chronic condition

Start date for new authorization (cannot be more than 30 days from submission) ___________________________

Initial start date of this episode of care: ___________________________

PROVIDER'S CONTINUED TREATMENT PLAN (requested services)

MODALITIES	FREQUENCY	ANTICIPATED COMPLETION
❑ Individual	❑ Weekly	❑ Less than 1 month
❑ In-home	❑ Twice per month	❑ 1 to 2 months
❑ Community based	❑ Monthly	❑ 2 to 4 months
❑ Less than monthly	❑ More than 4 months	

HOURS RECOMMENDED PER MONTH/WEEK: ___________________ CPT CODE 1: ______________________

HOURS RECOMMENDED PER MONTH/WEEK: ___________________ CPT CODE 2: ______________________

HOURS RECOMMENDED PER MONTH/WEEK: ___________________ CPT CODE 3: ______________________

____ ____________________

Provider Signature Date

My signature confirms that I am providing the requested services