HIGHMARK
NORTHEASTERN NEW YORK

Functional Behavior Assessment or Autism Spectrum Disorder Comprehensive Evaluation Request Form

Fax 1-833-581-1867
Phone: 1-844-946-6264

Requesting provider:_____ **Provider #**_____ **Phone:**_____ **Fax:** _____

Member name:_____ **DOB:**_____ **ID #:**_____ **Group #:**_____

COMPREHENSIVE EVALUATION REQUEST FOR NEWLY SCREENED PATIENTS:

Pre-screening completed to date:

Please submit copy of most recent history & physical completed within the past 6 months.

☐ **Yes** ☐ **No** Has the patient's physician completed the M-CHAT Autism screening?
If YES, please attach scoring results.
(M-CHAT *for children who are not school-age and/or non-verbal and/or have adaptive functioning)*

☐ **Yes** ☐ **No** Has the patient's parent/caregiver completed the ASSQ? If YES, please attach scoring results.
(ASSQ *for school-age children who are verbal and have higher adaptive functioning)*

Screening summary: Please check the item(s) below that correspond(s) to the patient's positive screening results.

M-CHAT
☐ Failed 2 or more **critical** questions
☐ Failed 3 or more questions

ASSQ
☐ Parent score of 19 or above
☐ Teacher score of 22 or above

Current medications and medical diagnoses:

FBA REQUEST FOR PATIENTS WITH AN ESTABLISHED ASD DIAGNOSIS:

Submit:

1. Copy of prior ASD evaluation completed by a developmental pediatrician, neurologist, psychiatrist, or licensed psychologist.
2. Results of comprehensive history and physical completed in the last 6 months.

Please note: The plan does not cover comprehensive autism evaluations for children unless they are pre-screened by their primary physician or have completed a comprehensive evaluation. A comprehensive autism evaluation is considered reasonable and necessary when screening tools indicate a high likelihood of an autism diagnosis. Medically necessary comprehensive evaluations will be covered when conducted by a licensed professional with expertise in the diagnosis and treatment of autism spectrum disorders. Prior comprehensive evaluations must be accompanied by the results of a complete history and physical conducted within 6 months of this request.

Servicing provider:_____ **Provider #:** _____

Phone:_____ **Codes requested:** _____

I attest that the above information is a complete and accurate account of the relevant member history and current clinical findings that have contributed to the development of the plan of care and detailed request as above.

Doctor's signature:_____ **Date:**_____