BlueCross BlueShield of Western New York

Outpatient Applied Behavior Analysis Treatment Report

Behavioral Health Utilization Management
Fax: (716) 887-7913
Phone: 1-877-837-0814

PATIENT: Name: _____
ID: _____ DOB: _____
Address: _____
City: _____ State: _____ ZIP: _____

PROVIDER: _____ ID: _____
Individual provider
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 and description:
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____ (highest past year) _____

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 others

SYMPTOMS — if present, check degree (x) or indicate Resolved/NA

	Mild	Mod.	Sev.	Resolved/NA		Mild	Mod.	Sev.	Resolved/NA
Anxiety	☐	☐	☐	☐	Inattention	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Obsessions	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Sleep disturbance	☐	☐	☐	☐

BEHAVIORS TARGETED FOR REDUCTION — if present, check degree (x) 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 (x) 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.