Please print clearly. Incomplete or illegible forms will delay processing. Please return the completed form to Bauer ABA For Adults And Children And Early Intervention team at 650-727-0025. For assistance, please call 650-727-0025

Fax: 650-727-0026

Member information

Patient name:	Legal guardian:
Member date of birth:	Medicaid/health plan #:
Gender: ▭ M ▭ F	Date of Initial diagnosis:
Age: Phone number:	Primary Diagnosis(required):

Provider information

Group/agency name:	▭ In network ▭ Out of network ▭ In credentialing process
Provider name:	Provider credential: ▭ MD ▭ PhD ▭ LMHP ▭ LBA ▭ SCABA ▭ Tech
Provider name:	Provider credential: ▭ MD ▭ PhD ▭ LMHP ▭ LBA ▭ SCABA ▭ Tech
Physical address:	Phone number: Fax number:
Medicaid/provider/NPI #:	Contact name:
Is this an initial authorization request? ▭ Yes ▭ No	Is this an annual review? ▭ Yes ▭ No

DSM diagnosis:

Primary Dx:	Secondary Dx:	Medical Dx:

Assessment and clinical documentation requirements:

All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide to Bauer ABA For Adults And Children And Early Intervention for a medical necessity determination.

1. Comprehensive Diagnostic Evaluation (CDE).

Treatment request:

ABA services	**Units**	**CPT code**	**Time frame (weekly/monthly)**	**Limitation reminders**
Behavioral Identification Assessment (ABA)				
Behavioral Identification Supporting Assessment				

Comments/additional information:

Provider signature

My signature confirms that any paraprofessional under my supervision has the appropriate education, training, and certifications as applicable.

_____ _____ _____

Provider signature	Credentials	Date