SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.694.3649

magnolia health

AUTISM SPECTRUM DISORDERS TREATMENT FORM

Please write clearly and only in designated areas. Incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Name ______________________________

Medicaid ID # ______________________________

Date of Birth ______________________________

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ______________________________

Credentials ______________________________

Address ______________________________
City/State/Zip Code

Phone ______________ Fax ______________

NPI ______________ Tax ID ______________

Service Requested______________________# of units______

Timeframe requested (that corresponds with Plan of Care) _______ to _______

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ______________________________

Credentials ______________________________

Address ______________________________
City/State/Zip Code

Phone ______________ Fax ______________

NPI ______________ Tax ID ______________

Service Requested______________________# of units______

Timeframe requested (that corresponds with Plan of Care) _______ to _______

PROVIDER INFORMATION AND SERVICE REQUESTED

Name ______________________________

Credentials ______________________________

Address ______________________________
City/State/Zip Code

Phone ______________ Fax ______________

NPI ______________ Tax ID ______________

Service Requested______________________# of units______

Timeframe requested (that corresponds with Plan of Care) _______ to _______

CURRENT DIAGNOSIS

Primary (Required): ______________________________

Secondary :______________________________

Tertiary :______________________________

Additional: ______________________________

Additional: ______________________________

CURRENT PRESENTATION/SYMPTOMS

Describe the CURRENT situation and symptoms and the impact on current functioning (occupational, academic, social, etc.).

	Mild	Moderate	Severe
______________________________	☐	☐	☐
______________________________	☐	☐	☐
______________________________	☐	☐	☐

MH/SA Treatment History - What has the member received in the past?

☐ NONE ☐ OP MH ☐ OP SA ☐ IP MH ☐ IP SA/DETOX ☐ OTHER

MEDICAL CONDITIONS AS REPORTED BY PARENT/GUARDIAN

COORDINATION OF CARE

Coordination has occurred with

PCP: ☐ Yes ☐ No Psychiatrist: ☐ Yes ☐ No

No treatment history

Name of Behavioral Health Specialist _____

Treatment plan has been reviewed with BH care coordinator:

☐ Yes ☐ No

Parent/guardian agrees with treatment goals: ☐ Yes ☐ No

TREATMENT PROGRESS

In addition to the information on this form, please attach:

- Treatment plan including the symptoms/behaviors requiring treatment (as indicated by the assessment tool)
- Identify SMART goals in specific, behavioral and measurable terms and progress made toward treatment goals, or if no progress reason why and plan to address lack of progress.
- Comprehensive Diagnostic Report (initial request only)
- List any other services the member is receiving (i.e PT/OT/ST/school)
- A sample schedule of treatment
- Documentation of parental involvement, parent goals

Information older than 30 days will not be accepted for concurrent review.

_____ _____
Provider Name and License/Credential Date

_____ _____
Provider Signature Date

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