
Provider Portal – Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Forms Training

Presentation Topics

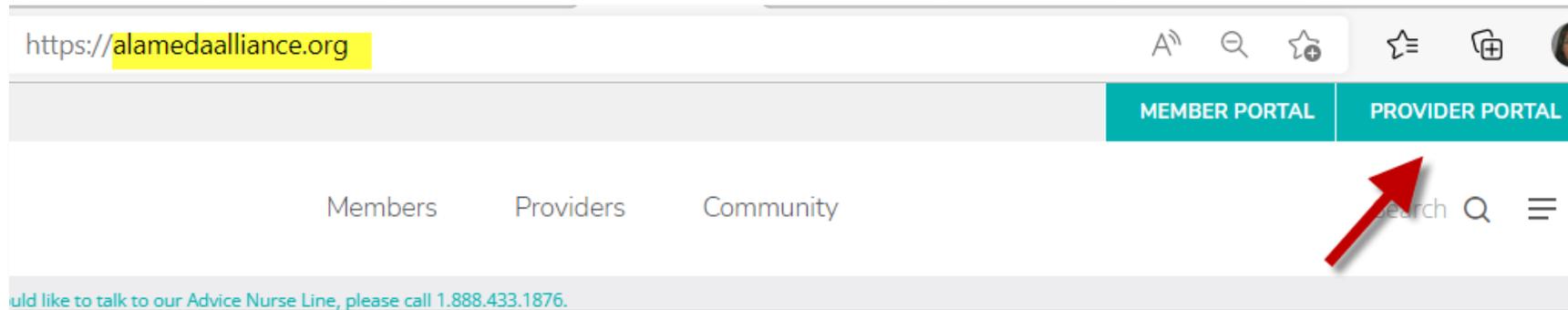
- ▶ How to create an account or log into the Alliance Provider Portal
- ▶ Navigating the Alliance Provider Portal to access the Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Forms
- ▶ Submitting an Initial BHT/ABA Form
- ▶ Submitting a Subsequent BHT/ABA Form
- ▶ Resources

How to create an account or log into the Alliance Provider Portal



Alliance Provider Portal

- ▶ Visit www.alamedaalliance.org.
- ▶ Click the **Provider Portal** button at the upper right corner of the webpage.



Alliance Provider Portal (cont.)

- ▶ Create an account or sign in.
- ▶ The **Provider Portal Instruction Guide** is available from the landing page with instructions on how to use the portal and its functionality.

WE ARE HERE TO HELP YOU

Helping our provider network improve efficiency, quality, and the patient experience.

As a provider and medical professional, the Alameda Alliance for Health provider site will give you the ability to check patient's eligibility, coverage, check claim status, update credentialing information, submit and view authorizations and referrals, collaborate on care plans, and more.

Provider Portal Instruction Guide

This guide will provide instructions on how to sign up for a provider portal account, what features are available, and how to navigate once you are logged into the provider portal. [Click here](#) to view the Provider Portal Instruction Guide.

News and Updates

«Avoid Waiting on the Phone. Use Our Automated Eligibility Verification Line!

Find A Doctor or Facility

[Click here](#) to search for a doctor, specialist or facility in the Alliance network.

Sign into your account

Username

Password

[Sign In](#) [Create Account](#)

[Forgot your username or password?](#)

If you are having issues authenticating your username or password, please call:
Alliance Provider Services Department
Monday - Friday, 7:30 am - 5 pm
Phone Number: 1.510.747.4510

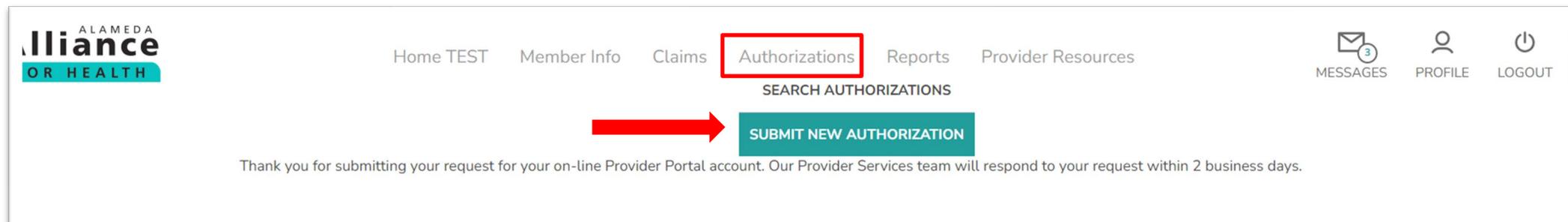
Online Services

- Access guidelines, materials
- Check member eligibility and benefits
- Find forms and other resources
- Review claim status
- Search the provider and facility directory

Navigating the Alliance Provider Portal to access the Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Forms

Accessing the BHT/ABA Authorization Form

- ▶ Hover over **Authorizations** from the menu bar
- ▶ Click **SUBMIT NEW AUTHORIZATION**



Submitting the BHT/ABA Treatment Plan-Authorization Form

- ▶ To access the form, click the teal text [here](#) next to For Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Treatment Plan-Authorization Request Form.

The screenshot shows the Alliance Provider Portal website. At the top left is the logo for Alliance ALAMEDA FOR HEALTH. To the right of the logo is a navigation menu with links for Home TEST, Member Info, Claims, Authorizations, Reports, and Provider Resources. On the far right of the navigation bar is the text "ME". Below the navigation bar is a welcome message: "Thank you for using the Alliance Provider Portal. We are here to help you. On this page, you can select a form to submit a request for authorization or access other online forms." Below this message is a list of links for different types of authorizations. The link for "For Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Treatment Plan-Authorization Request form" is highlighted with a black rectangular box, and a red arrow points to the teal text "here" in that link. Other links include "For Behavioral Health Outpatient*", "For Hospital, or Skilled Nursing admission or Discharge forms", "For Inpatient Elective Authorizations", "For Long-Term Care (LTC) forms", "For Mental Health forms", and "For Outpatient Elective Authorizations". At the bottom of the page is a footnote: "*Behavioral Health Prior Authorization Form for Applied Behavior Analysis (ABA), Functional Behavior Assessment (FBA), Psychological Testing, or Outpatient Transcranial Magnetic Stimulation (TMS)".

ALAMEDA
Alliance
FOR HEALTH

Home TEST Member Info Claims Authorizations Reports Provider Resources ME

Thank you for using the Alliance Provider Portal. We are here to help you. On this page, you can select a form to submit a request for authorization or access other online forms.

For Behavioral Health Outpatient*, please click [here](#).

For Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Treatment Plan-Authorization Request form, please click [here](#).

For Hospital, or Skilled Nursing admission or Discharge forms, please click [here](#).

For Inpatient Elective Authorizations, please click [here](#).

For Long-Term Care (LTC) forms including room and board or ancillary professional services, please click [here](#).

For Mental Health forms including Initial Evaluation/Coordination of Care Form, Coordination of Care Update Form, and referral forms, please click [here](#).

For Outpatient Elective Authorizations, please click [here](#).

*Behavioral Health Prior Authorization Form for Applied Behavior Analysis (ABA), Functional Behavior Assessment (FBA), Psychological Testing, or Outpatient Transcranial Magnetic Stimulation (TMS)

Submit an Initial or Subsequent Treatment Plan (TP) Prior Authorization (PA) Form

- ▶ To submit an initial or subsequent treatment plan (TP) prior authorization (PA) form that has **not yet** been initiated, click on **Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) Treatment Plan-Authorization Request Form**.

The screenshot shows the Alliance for Health portal interface. At the top left is the logo with a red arrow pointing to the 'FOR HEALTH' text. The main heading is 'Behavioral Health Treatment (BHT) / Applied Behavior Analysis (ABA) Forms'. In the top right corner, there is a user greeting 'Welcome Smith Aaron' and a 'Close' button. Below the heading, there are three search links: a main link for the request form, a link to search submitted forms, and a link to search incomplete forms. A red arrow points to the logo, and two blue arrows point from the search links to explanatory text on the right.

Click here to search for completed forms that were previously submitted. You can search by the tracking ID provided to you upon submission of that complete form.

Click here to search for any incomplete forms that you have saved and submitted but haven't yet completed. You can search by the tracking ID provided to you upon submission of that incomplete form.

Submit an Initial or Subsequent Treatment Plan (TP) Prior Authorization (PA) Form

- ▶ Please read the instructions before proceeding with the form!

Alliance ALAMEDA
FOR HEALTH

Behavioral Health Treatment (BHT) / Applied Behavior Analysis (ABA) Forms

Welcome Smith Aaron Close

Behavioral Health Treatment (BHT) /Applied Behavioral Analysis (ABA) Treatment Plan - Authorization Request Form

The Alameda Alliance for Health (Alliance) BHT/ABA Treatment Plan form is confidential. This form must be completed by a Board Certified Behavioral Analyst(BCBA). Filling out this form will help us better serve our members.

INSTRUCTIONS:
The form below is used for the initial and subsequent treatment plan submission and authorization requests.

How to submit the initial and subsequent request:

1. Search for a member by entering the member information below.
2. Click on "Select" button to view that member.
3. If member had a prior treatment plan (TP)/form submitted, it will be displayed in a table. You will have the option to "Load" or "Download" the prior forms/TPs.
 - a. To view and save the prior TP/ form, click on "Download"
 - b. To submit a subsequent request/updated TP, click on "Load" and the information that was entered in the prior form/TP will load/auto-populate in the form for you to utilize for the subsequent request.
4. If member does not have a prior form/TP (if this is the initial request/TP), you will not see anything displayed after clicking the "Select" button. You will be redirected to Section 1 (Member Information) and can start filling out the form.
5. If you wish to exit the form and return later to continue working on the form, please select "Save and Exit". You will receive a tracking ID # and an use that to search for your incomplete form.
6. Please attach all pertinent relevant medical records and clinical notes to this form.
7. For questions, please call the Alliance Provider Services Department at **1.510.747.4510**
8. The request date of the form is the date that you complete and submit the form.
9. Please complete the entire form within seven (7) days from starting the form.
10. Incomplete forms will be deleted after seven (7) days from start date.

PLEASE NOTE:
If the member has other case management needs (e.g., referral to a medical speech therapy, occupational therapy, complex case management, etc.) or if you have any other questions about the Alliance Case Management Program, please call the Alliance Case and Disease Management (CMDM) Department toll-free at **1.877.251.9612**.
If the member needs mental or behavioral health services, please call Alliance Provider Services Department at **1.510.747.4510**

How to Complete and Submit the Forms

Initial TP and Subsequent TP Form

- ▶ **Section 1 – Member Information**
 - ▶ Click the **magnifying glass** to search for member.
 - ▶ Select **Member ID/MCAL CIN/SSN or Name and Date of Birth.**
 - ▶ Click one (1) of the options highlighted in yellow to search by that category.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

The screenshot displays the '1 Member Information' section of a web form. At the top, there is a 'Member ID: *' input field with a magnifying glass icon to its right, which is highlighted with a red box. Below this field is a note: 'NOTE: Click on the search icon to search for a Member ID.' Below the note, there is a search bar with the text 'Member search by:' and two radio button options: 'AAH Member ID / MCAL CIN / SSN' (which is selected and highlighted with a red box) and 'Last Name, First Name, Date of Birth'. Below the search bar, there is a teal bar with the text 'Search by: AAH Member ID / MCAL CIN / SSN'. Below this, there is a 'Find a member by: *' section with three yellow-highlighted buttons: 'AAH Member ID', 'MCAL CIN', and 'SSN'. To the right of these buttons are input fields for 'First Name', 'Date of Birth', 'Address', and 'Status', along with 'Search' and 'Clear' buttons. Below the input fields, there are two sections, each starting with 'No data found'. The bottom right corner of the form has a 'Cancel' button.

How to Complete and Submit the Forms (cont.)

Initial TP Form

- ▶ If a member does not have a prior completed TP Form and this is the initial request for a treatment plan, you will not see anything displayed after clicking **Select**. You will be redirected to **Section 1 – Member Information** and can start filling out the form there.
- ▶ The member ID will display in the **Member ID** field. You will need to add the rest of the information and proceed to the next sections.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

1 Member Information

Member ID: *

NOTE: Click on the search icon to search for a Member ID.

Member Name: *

Date of Birth: *

Age: *

Parent/Caregiver Name: *

Caregiver's Relationship to Member: *

Phone Number: *

Enter Caregiver Relationship: *

Diagnosis

Date of Diagnosis/Diagnostic Report/Assessment:

Diagnosis:

Please type a minimum of three(3) characters to search for diagnosis.

[Add Diagnosis](#)

Code	Description	Primary	Action

[Upload file\(s\)](#)

Uploaded attachments:

File Name	File Type	File Size	Action

* Minimum file size for attachment is greater than 1KB, and Maximum file size is 2MB.
 * Allowed file extensions: License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).
 * File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, - (dash), _ (underscore) and spaces.

[Save And Exit](#)
[Save And Next](#)

How to Complete and Submit the Forms (cont.)

Subsequent TP (Progress Report)

- ▶ If a member had a prior TP Form submitted, it will be displayed in the table once you click **Select**.
- ▶ To update and submit the subsequent TP requests (Progress Report), click **Load**.
- ▶ You will be redirected to **Section 1 – Member Information** to continue the form. The information that was entered in the prior form (the one you selected to load) will be populated in Section 1.
- ▶ You can edit and update the information in Section 1, if needed.
- ▶ The following slides will provide instructions for the remaining sections. For subsequent TP requests or prior authorization submissions, the information you entered in the prior form will be populated and you can edit and update the sections as needed. If the information remains the same, you do not need to re-enter it since it will already be there.

Member search by: AAH Member ID / MCAL CIN / SSN Last Name, First Name, Date of Birth

Search by: AAH Member ID / MCAL CIN / SSN

Find a member by: *
AAH Member ID AAH Member ID *
NOTE: Add leading zeros to Member ID.

Action	Member ID	ID Type	Last Name	First Name	Date of Birth	Address	Status
<input type="button" value="Select"/>	994150852	HSN	TSEGAY	EZEKIEL	2021-02-22	4837 LOCH LN	ACTIVE

Action	Tracking ID	Submitted Date
No data found		

Member search by: AAH Member ID / MCAL CIN / SSN Last Name, First Name, Date of Birth

Search by: AAH Member ID / MCAL CIN / SSN

Find a member by: *
AAH Member ID AAH Member ID *
NOTE: Add leading zeros to Member ID.

Action	Member ID	ID Type	Last Name	First Name	Date of Birth	Address	Status
<input type="button" value="Select"/>	994150852	HSN	TSEGAY	EZEKIEL	2021-02-22	4837 LOCH LN	ACTIVE

Action	Tracking ID	Submitted Date
<input type="button" value="Load"/>	TU20241219144546228	12/19/2024
<input type="button" value="Download"/>	TI20241204130407195	12/04/2024

Treatment Plan (TP) Form

Section 1 – Member Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If the member does not have an established diagnosis (Dx), you can leave the **Date of Diagnosis** field blank.
- ▶ At least one (1) diagnosis code is required for prior authorization. If the member does not have an established Dx, enter **F98.9** or **F989**.
- ▶ Once you start entering the Dx code, you will see the options and can select the correct one.
- ▶ Click **Add Diagnosis** to add each code. This will appear in a table format.
- ▶ To add attachments (e.g., diagnostic assessments, primary care provider (PCP) referrals), click **Upload** and attach your files.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

1 Member Information

Member ID: * Q

NOTE: Click on the search icon to search for a Member ID.

Member Name: * Date of Birth: *

Age: * Parent/Caregiver Name: *

Caregiver's Relationship to Member: * Phone Number: *

Enter Caregiver Relationship: *

Diagnosis

Date of Diagnosis/Diagnostic Report/Assessment: 📅

Diagnosis: ① *

Please type a minimum of three(3) characters to search for diagnosis.

➔ Add Diagnosis

Code	Description	Primary	Action

➔ Upload file(s)

Uploaded attachments:

File Name	File Type	File Size	Action

* Minimum file size for attachment is greater than 1KB, and Maximum file size is 2MB.
* Allowed file extensions: License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).
* File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, -(dash), _ (underscore) and spaces.

Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 2 – Provider Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ **Qualified Autism Services Provider (BCBA)** – Click the **magnifying glass** to search for requesting provider by provider **NPI, TIN, or Last Name/Organization** and **First Name**. This will be the individual our team will usually contact if we have clinical questions regarding members’ TPs.
- ▶ **QAS Professional (this may be the mid-level supervisor)** – Enter this individual’s information in the fields.
- ▶ **QAS Para-Professional (this is the BI/Behavior Therapist)** – Enter this individual’s name.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

2 Qualified Autism Service (QAS) Provider Information

Qualified Autism Service Provider (BCBA)

Requesting Provider NPI-BCBA: *
 Provider

Last Name or Organization Name: *

First Name: *

Phone Number: *

Provider Group: *

Credentials:

Email: *

QAS Professional ←

Full Name: *

Phone Number: *

Credentials: *
 Other

Email: *

Enter Credentials: *

QAS Para-Professional ←

Full Name: *

Treatment Plan (TP) Form (cont.)

Section 3 – Member PCP Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ The PCP information should auto-populate in the appropriate fields based on the member ID. If the member does not have an assigned PCP, you will see a note indicating that.
- ▶ Complete the next required sections regarding care coordination with the member’s PCP.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

These fields will auto-populate.

3 Member PCP Information

PCP/Clinic Name: *	PCP NPI: *
<input type="text"/>	<input type="text"/>
Phone Number: *	Email:
<input type="text"/>	<input type="text"/>
Fax:	Address:
<input type="text"/>	<input type="text"/>
City:	State:
<input type="text"/>	<input type="text"/>
Zip:	<input type="text"/>
<input type="text"/>	<input type="text"/>

Has coordination of care occurred with Member's Primary Care Physician?: * Yes No

If Yes, please provide date and a brief description, If No, please explain why: * (Characters Remaining 0/5000)

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 4 – Basic Background Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ For the **current or prior services** section, select the appropriate option.
 - ▶ If the member is not receiving any other services, select **No Current or Prior Services**.
 - ▶ If none apply, select **Other** and enter the information in the text box.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

4
Basic Background Information

Reason for referral: * (Characters Remaining 0/5000)

Please describe the primary concern(s) of the parent/caregiver: * (Characters Remaining 0/5000)

Please describe the medical and behavioral health history, including treatment and medication (if applicable): (Characters Remaining 0/5000)

Please select the current or prior services (e.g., ABA, speech, occupational, social skills group, etc.)(please select all that apply): *

<input type="checkbox"/> ABA	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Social Skills Group	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> No Current or Prior Services	<input checked="" type="checkbox"/> Other Medical Services

Please provide additional information regarding current or prior services, as needed: (Characters Remaining 0/5000)

Please describe member's strength(s): * (Characters Remaining 0/5000)

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 4 – Basic Background Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If the member has availability on that day, type in the time range in **Time** column next to each day (e.g., 2pm-5pm). If member is not available on that day (e.g., Friday), type in **N/A** in the **Time** column next to that day of the week.
- ▶ In the next table, list the member's current/proposed schedule for ABA treatment. Select the setting from the drop-down options in the **Setting** column. If member is not available on that day (e.g., Friday), type in **N/A** in the **Time** column and select **Other** from the **Settings** options and type in **N/A** as displayed in the example here.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

5 Member and Family's Availability for ABA Services

Please provide the member and family's availability for ABA services in the table below (please enter the availability each day and time ranges for each day): *

Day	Time
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	NA
Saturday	
Sunday	

Please provide the current/confirmed schedule for ABA services below, including the setting (e.g., clinic, home, community settings etc.): *

Day	Time	Setting
Monday		▼
Tuesday		▼
Wednesday		▼
Thursday		▼
Friday	NA	▼
Saturday		▼
Sunday		▼

Back Save And Exit Save And Next

Other ▼

Other:

NA

Treatment Plan (TP) Form (cont.)

Section 6 – Review of Prior Assessments/Documents

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ You must select at least one (1) option from the list provided. Provide a brief description of what was reviewed and any clinically relevant information that you think is important to note.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

6 Review of Prior Assessments/Documents

For the purposes of conducting this assessment, please select each assessment you have reviewed and provide details: *

Character Limit: 5000

Diagnostic reports/assessments

Please specify

Individualized Education Plan (IEP) (if applicable)

Please specify

Individual Family Service Plan (IFSP) or Individualized Program Plan (IPP) from a regional center (if applicable)

Please specify

Prior Functional Behavior Assessment (FBA) or Progress Report

Please specify

Assessments/Reports Of Other Services Provided (e.g., OT, ST, PT, etc.)

Please specify

Mental Health Treatment/Assessments

Please specify

Other (please specify)

Please specify

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 7 – Coordination of Care with other Service Providers (in the last six (6) months)

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ You must select **Yes** or **No**.
 - ▶ If you select **Yes**, complete all fields that apply and are required. If care coordination occurred with multiple individuals, you can add their information one-by-one. Once you add the first individual, click **Add Coordination of Care** and that individual will be listed in a table. You can then add additional individuals, if needed.
 - ▶ If you select **No**, please add your explanation in the text field.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

7 Coordination of Care with Other Service Providers

Has coordination of care occurred with other service providers in the **last 6 months?** *

Yes No

Date: *

Name/Person You Coordinated Care With: *

Email: Phone Number: Purpose of Communication: *

Comments: * (Characters Remaining 0/5000)

Add Coordination of Care

Date	Name/Person You Coordinated Care With	Email	Phone Number	Purpose of Communication	Comments	Action

Back Save And Exit Save And Next

7 Coordination of Care with Other Service Providers

Has coordination of care occurred with other service providers in the **last 6 months?** *

Yes No

Please explain: * (Characters Remaining 0/5000)

Back Save And Exit Save And Next

Treatment Plan (TP) Form (cont.)

Section 8 – School Information

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If the member is not attending school/not school-aged, you do not need to enter anything in this section.
- ▶ If the member is attending school and has an active Individual Education Plan (IEP), please select the services the member is receiving at school. If none apply, select **Other** and list the other IEP service/services.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

8 School Information

School Name:

Class Type / Placement:

School Schedule (Please list the days of the week and time, eg: Monday - Friday 8AM - 3 PM): (Characters Remaining 0/5000)

IEP services that the member is receiving at school (if any):

<input type="checkbox"/> Applied Behavior Analysis	<input type="checkbox"/> Behavioral Intervention	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Social Skills Group	<input type="checkbox"/> Speech Therapy	<input checked="" type="checkbox"/> Other

Other IEP services: *

Treatment Plan (TP) Form (cont.)

Section 9 – Assessment Methods

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If you did not utilize any of the assessment methods listed here or the FBA was not warranted, type in **N/A** in the required fields and add your notes/explanation in the **Other** field.
- ▶ To add attachments, click **Upload File(s)** and upload your attachments. Each attachment will then appear in the **Uploaded attachments** table.
- ▶ For the **Skills Assessment**, please note that you will be asked to provide the results for the skills assessment(s) and additional details in **Section 11 – Skills Assessment**.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

9 Assessment Methods

Please list all assessment methods that were used during the initial Functional Behavior Assessment (FBA) and progress reports and provide a brief description of the methods or documents reviewed:
Character Limit: 5000

Indirect Assessment (e.g., FAST, QABF, structured parent interview): *

Descriptive Assessment (e.g., ABC data collection, observation notes): *

Functional Analysis (e.g., brief, standard):

Baseline Data Collection: *

Skills Assessment (please list all the skills assessments utilized): *

Direct Home Observation (please include the date of observation and a brief description): *

Direct School Observation (please include the date of observation and a brief description):

Preference Assessment (please list all the preference assessments utilized): *

Other:

Uploaded attachments: Upload file(s)

File Name	File Type	File Size	Action
* Minimum file size for attachment is greater than 1KB, and Maximum file size is 2MB.			
* Allowed file extensions: License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).			
* File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, - (dash), _ (underscore) and spaces.			

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 10 – Preference Assessment and Established Reinforcers

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ At least one (1) is required.
 - ▶ **Please Note:** These are examples of commonly used preference assessments, if none apply or you would like to add additional methods not listed here, please select **Other** and enter the other methods used/details in the **Other** field.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

10 Preference Assessment and Established Reinforcers

Please provide the corresponding established reinforcers for each type of preference assessment: *

Character Limit: 5000

Paired Stimulus

Please specify

Single Stimulus

Please specify

Multiple Stimuli

Please specify

Free Operant

Please specify

Other

Please specify

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 11 – Skills Assessment

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Please read the instructions and list the **Skills Assessments** utilized during this assessment process (e.g., Vineland, VB-MAPP). At least one (1) is required. The assessment results should be updated every six (6) months and included in the subsequent requests.
- ▶ To add the results of the assessment (graphs/tables), click **Upload File(s)** and upload your attachments. Each attachment will then appear in the **Uploaded attachments** table.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

11 Skills Assessment

Please conduct a formal skills assessment (e.g., Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Vineland, Adaptive Behavior Assessment System (ABAS), etc.) no less than once every six (6) months, provide results and date of assessment in the initial FBA and subsequent progress reports/re-assessments. For subsequent treatment plans/progress reports, please include previous results for comparison. Please list all skill assessment utilized for the treatment plan in the text box and attach the assessment results in the Attachment section: * (Characters Remaining 0/5000)

Upload file(s)

Uploaded attachments:

File Name	File Type	File Size	Action
<p>* Minimum file size for attachment is greater than 1KB, and Maximum file size is 2MB.</p> <p>* Allowed file extensions: License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).</p> <p>* File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, - (dash), _ (underscore) and spaces.</p>			

Back

Save And Exit

Save And Next

Treatment Plan (TP) Form (cont.)

Section 12 – Goals Met

- ▶ When completing the initial assessment, select **Initial Treatment Plan**. You do not need to complete this section for the Initial TP Form submission.
- ▶ When completing the subsequent form/submitting the progress report, select **Subsequent Treatment Plan**. Add the goals that were met in the last authorization period in this section. Once you are done adding the goal, click **Add Goal**. The goals will be listed in a table on this page.
- ▶ If member did not meet any goals during last authorization period, you can leave it blank.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

12 Goals Met

NOTE: If this is an initial treatment plan, add all new/proposed goals in sections 13, 14, and 15

Initial Treatment Plan
 Subsequent Treatment Plan

Please provide all previously mastered goals for the last (6) months. This will serve as a quick reference on the progress that the member has made over the last (6) months.

Goals:

Goals	Date Met	Action

Treatment Plan (TP) Form (cont.)

Section 13 – Behaviors Targeted for Decrease

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Select if there are behavior reduction goals being targeted.
 - ▶ If there are no behavioral reduction goals or behavioral concerns that need to be targeted in the member’s TP Form, select **No**. If you select **No**, you do not need to complete the remainder of this section.
 - ▶ If you are proposing behavior reduction goals, select **Yes** and complete the rest of the fields for each goal.
- ▶ The yellow highlighted field on the right is not required and should only be completed if it applies to the member/member’s TP.
- ▶ Click **Add Goal** after each goal and enter the details. The details that you entered in each field will be transferred to a table in this section.
 - ▶ You can edit the goal and details or delete the goal from the table, as needed.
 - The **pencil** icon allows you to edit.
 - The **trash can** icon allows you to delete.

13 Behaviors Targeted for Decrease

Are there any behavioral reduction goals being targeted?: *

Yes No

Please use the format below for all new behavior reduction goals.
PLEASE NOTE: If goal is met, add the goal in the Goals Met section above in section 12.

<p>Operational Definition of Behavior: ⓘ *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>Observed Antecedents: *</p> <input style="width: 95%; height: 20px;" type="text"/>
<p>Observed Consequences: *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>Indirect Assessment: ⓘ *</p> <input style="width: 95%; height: 20px;" type="text"/>
<p>Hypothesized Function (based on direct observation): *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>Baseline of Target Behavior: ⓘ *</p> <input style="width: 95%; height: 20px;" type="text"/>
<p>Date First Targeted: ⓘ</p> <input style="width: 95%; height: 20px;" type="text"/> <input type="calendar"/>	<p>Anticipated Date of Mastery: *</p> <input style="width: 95%; height: 20px;" type="text"/> <input type="calendar"/>
<p>Behavior Reduction Goal: ⓘ *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>History of Problem Behavior: *</p> <input style="width: 95%; height: 20px;" type="text"/>
<p>Replacement Behavior Goal: *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>Antecedent-Based Interventions: *</p> <input style="width: 95%; height: 20px;" type="text"/>
<p>Consequence-Based Interventions: *</p> <input style="width: 95%; height: 20px;" type="text"/>	<p>Goal is being targeted at: *</p> <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Center/Clinic <input type="checkbox"/> Other
<p>Current Status: *</p> <input style="width: 95%; height: 20px;" type="text"/>	

Please provide a clinical rationale and a proposed plan to address the barriers to progress, if there is an increase in maladaptive behavior:
 (Characters Remaining 0/5000)

Add Goal

Treatment Plan (TP) Form (cont.)

Section 13 – Section 15 (Updating Goals)

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ In Sections 13-15: The subsequent requests/TPs goals that were added in the prior TP section will appear in a table.
- ▶ To update the goal/progress status, click the **pencil** icon. The goal details will auto-populate in the corresponding fields for you to make updates and edits.

Please note: If goal is met, add the goal in the Goals Met section above in section 12.

Action	Goal #	Domain	Skill Acquisition Goal	Social Significance to Member	Baseline Data	Target/Goal Introduction Date	Anticipated Date of Mastery	Teaching Str
	1	testing	testing	testing	testing	12/04/2024	06/04/2025	testing

If a task analysis is included, please list the steps, teaching method (e.g., forward/ backward chaining, etc.), and mastery criteria. Please use the format below for all new goal currently being targeted

PLEASE NOTE: If goal is met, add the goal in the Goals Met section above in section 12.

Domain: *
testing

Skill Acquisition Goal: ⓘ *
testing

Social Significance to Member: *
testing

Baseline Data: ⓘ *
testing

Target/Goal Introduction Date: *
12/4/2024

Anticipated Date of Mastery: *
6/4/2025

Teaching Strategies/Instructional Methods to Be Used: ⓘ *
testing

Goal is being targeted at: *
 School Home Community Center/Clinic Other

Current status: *
New/Proposed

Please provide a clinical rationale for any decrease in performance and a proposed plan to address barriers to progress:
(Characters Remaining 7/5000)
testing

Treatment Plan (TP) Form (cont.)

Section 13 (cont.)

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ To add graphs, tables, or any other document, click **Upload File(s)** and upload your attachments. Each attachment will then appear in the **Uploaded attachments** table.
 - ▶ Progress data is **not required** for the Initial TP Form.
 - ▶ Progress data is **required** for subsequent treatment plans/progress reports.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

Please attach a document with a graph for each goal (including the goal number) during the current authorization period. Please include baseline data.

PLEASE NOTE: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month.

[Upload file\(s\)](#)

Uploaded attachments:

File Name	File Type	File Size	Action
<p>* Minimum file size for attachment is greater than 1KB, and Maximum file size is 2MB.</p> <p>* Allowed file extensions: License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).</p> <p>* File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, - (dash), _ (underscore) and spaces.</p>			

Please note: If goal is met, add the goal in the Goals Met section above in section 12.

Action Goal # Operational Definition of Behavior Observed Antecedents Observed Consequences Indirect Assessment Hypothesized Function (based on direct observation)

[Back](#) [Save And Exit](#) [Save And Next](#)

Treatment Plan (TP) Form (cont.)

Section 14 – Skill Acquisition/Skill Building Goals

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Enter each goal you are planning to target or are proposing.
- ▶ Click **Add Goal** after each goal and enter the details. The details that you entered in each field will be transferred to a table in this section.
 - ▶ You can edit the goal and details or delete the goal from the table, as needed.
 - The **pencil** icon allows you to edit.
 - The **trash can** icon allows you to delete.
- ▶ The highlighted field is not required and should only be completed if it applies to member/member's TP.
- ▶ To add graphs, tables, or any other document, click **Upload File(s)** and upload your attachments. Each attachment will then appear in the **Uploaded attachments** table.
 - ▶ Progress data is **not required** for the Initial TP Form.
 - ▶ Progress data is **required** for subsequent treatment plans/progress reports.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

14 Skill Acquisition/Skill Building Goals

If a task analysis is included, please list the steps, teaching method (e.g., forward/ backward chaining, etc.), and mastery criteria. Please use the format below for all new goal currently being targeted

PLEASE NOTE: if goal is met, add the goal in the Goals Met section above in section 12.

Domain: *

Skill Acquisition Goal: ⓘ *

Social Significance to Member: *

Baseline Data: ⓘ *

Target/Goal Introduction Date: *

Anticipated Date of Mastery: *

Teaching Strategies/Instructional Methods to Be Used: ⓘ *

Goal is being targeted at: *

 School Home Community Center/Clinic Other

Current status: *

Please provide a clinical rationale for any decrease in performance and a proposed plan to address barriers to progress:
(Characters Remaining 0/5000)

Add Goal

Please attach a document with a graph for each goal (including the goal number) during the current authorization period. Please include baseline data.

PLEASE NOTE: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month.

Upload file(s)

Uploaded attachments:			
File Name	File Type	File Size	Action

Please note: if goal is met, add the goal in the Goals Met section above in section 12.

Action	Goal #	Domain	Skill Acquisition Goal	Social Significance to Member	Baseline Data	Target/Goal Introduction Date	Anticipated Date of Mastery	Teaching Strate
←								

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Treatment Plan (TP) Form (cont.)

Section 15 – Parent/Caregiver Goals

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Enter each goal you are planning to target and are proposing.
- ▶ Click **Add Goal** after each goal and enter the details. The details that you entered in each field will be transferred to a table in this section.
 - ▶ You can edit the goal and details or delete the goal from the table, as needed.
 - The **pencil** icon allows you to edit.
 - The **trash can** icon allows you to delete.
- ▶ The highlighted field is not required and should only be completed if it applies to member/member's TP.
- ▶ To add graphs, tables, or any other document, click **Upload File(s)** and upload your attachments. Each attachment will then appear in the **Uploaded attachments** table.
 - ▶ Progress data is **not required** for the Initial TP Form.
 - ▶ Progress data is **required** for subsequent treatment plans/progress reports.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

15 Parent/Caregiver Goals

Please provide those previously mastered goals for the last 12 months, if a task analysis is included along with the corresponding established reinforcers for each type of preference assessment: This will serve as a quick reference on the progress of training and parent's or caregiver's

PLEASE NOTE: If goal is met, add the goal in the Goals Met section above in section 12.

Parent/Caregiver Goal: ⓘ * <input style="width: 95%;" type="text"/> Baseline Data: ⓘ * <input style="width: 95%;" type="text"/> Anticipated Date of Mastery: * <input style="width: 95%; border: 1px solid #ccc;" type="text" value="MM/DD/YYYY"/>	Purpose of Goal: * <input style="width: 95%;" type="text"/> Target/Goal Introduction Date: * <input style="width: 95%; border: 1px solid #ccc;" type="text" value="MM/DD/YYYY"/>
Data Collection Method: * <input style="width: 95%;" type="text"/> Training Setting: ⓘ * <input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Clinic <input type="checkbox"/> Other	Treatment Package: ⓘ * <input style="width: 95%;" type="text"/> Frequency of Parent Education Will Be Delivered for This Goal: ⓘ * <input style="width: 95%;" type="text"/> Current status: * <input style="width: 95%; border: 1px solid #ccc;" type="text"/>

Please provide a clinical rationale for any decrease in performance and a proposed plan to address barriers to progress:
(Characters Remaining 0/5000)

Add Goal

Please attach a document with a graph for each goal (including the goal number) during the current authorization period. Please include baseline data.

PLEASE NOTE: If a mastery criterion was defined as per session/week/month, then the data on the graph must be displayed as per session/week/month

Uploaded attachments: Upload file(s)

File Name	File Type	File Size	Action
Minimum file size for attachment is greater than 1KB, and maximum file size is 2MB.			

* Allowed file extensions:
 License file(.lic), Word documents(.doc, .docx), Excel documents(.xls, .xlsx), Powerpoint documents(.ppt, .pptx), Text files(.txt), Richtext documents(.rtf), Portable Document Format(.pdf), Bitmap image file(.bmp), Image file (.jpg, .gif, .tif).

* File name for the attachment should be maximum 100 characters including extension, allowed characters A-Z, a-z, 0-9, - (dash), _ (underscore) and spaces.

Please note: If goal is met, add the goal in the Goals Met section above in section 12.

Action	Goal #	Parent/Caregiver Goal	Purpose of Goal	Baseline Data	Target/Goal Introduction Date	Anticipated Date of Mastery	Treatment Package	Data Collection M

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Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 16 – Crisis Plan

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If the member does not engage in any behaviors that warrant a crisis plan, please add that in the field. You can also add a more generic crisis plan.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

16 Crisis Plan

Please provide a detailed crisis plan should the member have any maladaptive behaviors that could result in any potential physical harm/injury to the member and/or others involved. If member does not engage in maladaptive behaviors that warrant a crisis plan (e.g. de-escalation plan for severe maladaptive behaviors), please include a more generic crisis plan that family and staff can follow when needed: *

(Characters Remaining 0/5000)

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Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 17 – Generalization Plan

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

The screenshot shows a form titled "17 Generalization Plan". Below the title is a text input field with the placeholder text "Please indicate how your team will target generalization of goals/skills: * (Characters Remaining 0/5000)". At the bottom right of the form, there are three buttons: "Back", "Save And Exit", and "Save And Next". These buttons are highlighted with a red rectangular border.

Treatment Plan (TP) Form (cont.)

Section 18 – Discharge/Exit Plan and Criteria

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

18 Discharge/Exit Plan and Criteria

Please provide an individualized discharge plan and criteria for this member. *

Providers should consider the following when planning for discharge:

- Has the member achieved treatment goals?
- Does the member demonstrate progress towards goals for successive authorization periods?
- Are the parents or caregivers interested in discontinuing services?
- Are members and family able to generalize skills across multiple settings?
- Are there any issues in treatment planning and delivery that cannot be reconciled?
- Is the member ready to move from the current level of service to a lower level of service (i.e., social skills group therapy, community resources, parent consultation model)?
- Is member's age impacting eligibility for continued services? (For example, member is turning 21 years old)

(Characters Remaining 0/5000)

Treatment Plan (TP) Form (cont.)

Section 19 – Significant Barriers to Progress

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If there are no barriers to report, please type in **N/A** in this field.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

The screenshot shows a form titled "19 Significant Barriers to Progress". Below the title is a text input field with the instruction: "Please explain the barriers to progress during this reporting period and steps taken to address these barriers (please be specific): *". Below the instruction is a character count: "(Characters Remaining 0/5000)". At the bottom right of the form, there are three buttons: "Back", "Save And Exit", and "Save And Next". The buttons are highlighted with a red border.

Treatment Plan (TP) Form (cont.)

Section 20 – Service Utilization Chart

- ▶ This section is not required for the Initial TP Form.
- ▶ For the subsequent request, please complete all the fields to indicate the hours utilized during the last authorization period. The **Percent Utilized** will be auto-calculated once the other fields are filled out.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

20 Service Utilization Chart for this Reporting Period for direct ABA/H2019

Providers are required to provide a service utilization chart for each progress report/subsequent treatment plans only.

PR Start Date:

PR End Date:

Total Number of Direct Hours Authorized: <input type="text" value="10"/>	Total Number of Hours Canceled by the Caregiver: <input type="text"/>
Total Number of Direct Hours Utilized/Delivered: <input type="text" value="2"/>	Total Number of Hours Canceled by the Provider: <input type="text"/>

Percent Utilized:

Total number of sessions in which caregiver(s) actively participated in the child's ABA programming during this reporting period:

If percent utilization is less than 60%, please provide justification by selecting an option:

Excessive cancellations by family
 Excessive cancellations by staff
 Family preference
 Lack of staffing
 Other

Please explain: *

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Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 21 – Summary and Recommendations

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ If the **Level of Urgency is Routine** – Our ABA team has up to five (5) business days to make the determination (approve, deny, or request for more information). For routine requests, the authorization end date will automatically be set to six (6) months from the request date.
- ▶ If the **Level of Urgency is Retro/Post Service** – Please review the instructions our team provided for how to submit retro requests. Our ABA team has up to 30 calendar days to make the determination (approve, deny, or request for more information).
- ▶ **Place of Services** – Where services will take place. Select the appropriate option.
- ▶ **Procedure codes** – Once you start typing in the code, you will see a list of options that you can select from.
 - ▶ **Please Note:** We do not use CPT codes for ABA treatment. We utilize HCPCs codes (H2019, H2014, H2012, H0031, H0032, and S5111).

21 Summary and Recommendations

Please indicate the clinical team's recommended treatment intensity based solely on the member's medical necessity (i.e., based solely on the severity of the child's deficits and behavioral symptoms). Please provide the actual number of units being requested for the upcoming authorization when considering the family's availability: *

<p>Level of Urgency: * <input type="text"/></p> <p>Authorization Start Date: ⓘ * <input type="text" value="MM/DD/YYYY"/></p> <p>Procedure Code & Description: * <input type="text"/></p> <p>Total Number of Units Requested: * <input type="text"/></p>	<p>Place of Service: * <input type="text"/></p> <p>Authorization End Date: ⓘ * <input type="text" value="MM/DD/YYYY"/></p> <p>Total number of Units Based on the Medical Necessity: * <input type="text"/></p> <p>Total Number of Hours per Month Requested: * <input type="text"/></p> <p style="text-align: right;">Add Procedure Code</p>
---	--

Procedure Codes & Description	Total # of Units based on the medical necessity	Total # of Units requested	Total # of Hours per month requested	Action
<p>Rendering Provider NPI: * <input type="text" value="Provider"/></p> <p>First Name: * <input type="text"/></p>				
<p>Last Name or Organization Name: * <input type="text"/></p>				

[Back](#)
[Save And Exit](#)
[Save And Next](#)

Treatment Plan (TP) Form (cont.)

Section 21 – Summary and Recommendations (cont.)

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ For **Total Number of Units Based on the Medical Necessity**, enter the units you are recommending.
- ▶ For **Total Number of Units Requested**, enter the units you are requesting for this authorization (based on the member or family’s availability). This may be the same number of units that are medically necessary, or it might be less due to the member or family’s availability.

This is the number of units that gets added to the prior authorization request.

- ▶ For **Total Number of Hours per Month Requested**, enter the number of hours.
- ▶ Click **Add Procedure Code** to add each code along with the details you entered in the above fields. The codes and details will be displayed in a table. You can make edits, if needed.
- ▶ One you add the first procedure code you will need to complete these fields for any additional codes and add them.

21 Summary and Recommendations

Please indicate the clinical team’s recommended treatment intensity based solely on the member’s medical necessity (i.e., based solely on the severity of the child’s deficits and behavioral symptoms). Please provide the actual number of units being requested for the upcoming authorization when considering the family’s availability: *

Level of Urgency: *

Authorization Start Date: ⓘ *

Procedure Code & Description: *

Total Number of Units Requested: *

Place of Service: *

Authorization End Date: ⓘ *

Total number of Units Based on the Medical Necessity: *

Total Number of Hours per Month Requested: *

Add Procedure Code

Procedure Codes & Description	Total # of Units based on the medical necessity	Total # of Units requested	Total # of Hours per month requested	Action
<p>Rendering Provider NPI: * <input type="text" value="Provider"/></p> <p>First Name: * <input type="text"/></p>				<p>Last Name or Organization Name: * <input type="text"/></p>

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Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 21 – Summary and Recommendations (cont.)

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Enter the servicing provider information in the section framed in red on the right. You can search by provider NPI, or Name.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

21 Summary and Recommendations

Please indicate the clinical team's recommended treatment intensity based solely on the member's medical necessity (i.e., based solely on the severity of the child's deficits and behavioral symptoms). Please provide the actual number of units being requested for the upcoming authorization when considering the family's availability: *

Level of Urgency: * <input type="text"/>	Place of Service: * <input type="text"/>
Authorization Start Date: ⓘ * <input type="text" value="MM/DD/YYYY"/>	Authorization End Date: ⓘ * <input type="text" value="MM/DD/YYYY"/>
Procedure Code & Description: * <input type="text"/>	Total number of Units Based on the Medical Necessity: * <input type="text"/>
Total Number of Units Requested: * <input type="text"/>	Total Number of Hours per Month Requested: * <input type="text"/>

[Add Procedure Code](#)

Procedure Codes & Description	Total # of Units based on the medical necessity	Total # of Units requested	Total # of Hours per month requested	Action
-------------------------------	---	----------------------------	--------------------------------------	--------

Rendering Provider NPI: * <input type="text" value="Provider"/>	Last Name or Organization Name: * <input type="text"/>
First Name: * <input type="text"/>	

Back
Save And Exit
Save And Next

Treatment Plan (TP) Form (cont.)

Section 22 – Parents/Caregivers Consent

- ▶ Complete all fields that apply. Required fields are marked with an asterisk (*).
- ▶ Indicate if the TP/report was shared and reviewed with the member’s parents/caregivers.
 - ▶ If you select **Yes**, please complete the other fields.
 - ▶ If you select **No**, please provide the explanation in the provided field and include the date you plan to have the discussion with the parents/caregivers.
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Save And Exit** if you wish to leave the form.
- ▶ Click **Save And Next** to proceed to the next section and continue with the form.

22 Parents/Caregiver's Consent for Treatment Plan/Report

Please indicate if the treatment plan/report was shared and reviewed with the member's parents/caregivers: *

Yes No

Treatment plan/report shared and reviewed date:

MM/DD/YYYY

Did the parents/caregivers agree with the proposed treatment plan?:

Back Save And Exit Save And Next

22 Parents/Caregiver's Consent for Treatment Plan/Report

Please indicate if the treatment plan/report was shared and reviewed with the member's parents/caregivers: *

Yes No

Please explain: (Characters Remaining 0/5000)

Back Save And Exit Save And Next

Treatment Plan (TP) Form (cont.)

Section 23 – Preview and Submit

- ▶ Review all the sections and the information you have entered and have an opportunity to make edits, if needed.
 - ▶ To edit a section, click on the **pencil icon** in red.
 - ▶ If no edits are needed, scroll down the form to the section on the right to the preview page.
- ▶ Check the box and enter the information if you are the designee signing on behalf of the BCBA. **This section must be complete before you can submit the TP Form.**
- ▶ Click **Back** if you wish to go back to the prior section.
- ▶ Click **Reset** to clear and reset form.
- ▶ Click on **Submit** if you are ready to submit the form.

By signing below you are attesting that this treatment report has been reviewed and approved by the responsible BCBA or BCBA-D.

* Designee signing on behalf of BCBA or BCBA-D

Full Name of Designee _____ Name of BCBA _____

Signature of BCBA/Designee * _____

Back **Reset** **Submit**

Resources

We are here to help

- ▶ Alliance Website: www.alamedaalliance.org
- ▶ Provider Manual: www.alamedaalliance.org/providers/alliance-provider-manual/
- ▶ Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
Email: ProviderServices@alamedaalliance.org

Thank you!