SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone: 1.877.658.0305 FAX 1.866.694.3649

Applied Behavior Analysis (OTR) Form

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

MEMBER INFORMATION

Name ______________________________

Medi-Cal 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 ________

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 ICD DIAGNOSIS

Primary ______________________________

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

CURRENT IMPULSIVE/ OR DANGEROUS BEHAVIORS

Safety plan in place? ☐ Yes ☐ No

INITIAL AND RE-EVALUATION REQUESTS

Medication name _____ Dosage_____

Medication name _____ Dosage_____

Medication name _____ Dosage_____

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

PSYCHIATRIC TREATMENT HISTORY

Inpatient: ☐ Yes ☐ No When _____

Therapist NA: ☐ Yes ☐ No

Name of Behavioral Health Specialist _____

TREATMENT PROGRESS

Level of improvement to date:

Minor ☐ Moderate ☐ Major ☐ No Progress to date ☐

TREATMENT PROGRESS

Please give a brief description of member's progress or lack of progress towards goals

_____ _____

Provider Name and License/Credential Date

The IBP and POC must be submitted with this OTR so the request for services may be reviewed.

_____ _____

Provider Signature Date

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone: 1.877.658.0305 FAX 1.866.694.3649