blue california
Promise Health Plan

ATTENTION: PLEASE READ

Applied Behavior Analysis (ABA) treatment is a specific type of behavioral health treatment that addresses socially significant behaviors (e.g., maladaptive behaviors, social interactions, communication, and self-help skills) through the application of behavioral strategies. Treatment typically occurs in the setting these behaviors are desired to occur (e.g., homes, schools, community, etc). ABA was first implemented with individuals with Autism and intellectual disability and empirical research has mostly been concentrated on efficacy with these populations.

To make a referral to start Applied Behavior Analysis (ABA), conduct your own assessment, determine that the member can benefit from ABA treatment, and fill out the attached form with the member's family. If you have pertinent screening forms or medical records, please attach them to the form. Please include the ICD-10 code/diagnosis (possible diagnosis or symptoms) on the forms. Once Blue Shield of California Promise Health Plan receives your referral, the first step in starting ABA services is having a board-certified behavior analyst (BCBA) conduct a functional behavior assessment (FBA).

Note: Effective April 1, 2023, prior authorization is not required for psychological testing, neuropsychological testing, or a comprehensive diagnostic evaluation (CDE). A CDE is no longer required prior to referring a member for ABA services.

Please have the parent/caregiver call our team so that we may educate them on the referral process.

If you have questions, please submit your inquiries to BHTProgram@blueshieldca.com or call (888) 297-1325.

Behavioral Health Treatment phone: (888) 297-1325
Behavioral Health Treatment fax: (844) 283-3298

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Applied Behavioral Analysis referral form

*This completed recommendation form is required before ABA services will be authorized. If you are not recommending or prescribing ABA treatment for the patient, this form does not need to be filled out.

This form must be completed by a Physician or Licensed Clinical Psychologist within the last 12 months.			
Member First Name	Member Last Name		
Member ID	Preferred Spoken Language		
Address	City	ZIP Code	
Date of Birth	Gender ☐ Male ☐ Female		
Primary Diagnosis			
Secondary Diagnosis			
Parent/Caregiver Name	Relationship to Member	Primary Phone Number	
Date Member Was Last Seen	Duration You Have Treated Member		
Is ABA recommended? ☐ Yes ☐ No	Has the member received ABA services previously? ☐ Yes ☐ No		
Alternate Treatment Recommendation			
Referring Provider First and Last Name (Please print)	Referring Provider Phone Number		
Referring Provider Fax Number			
Signature of Referring Provider	Date	License Type	License Number

ABA Referral Reason – Referring Physician. or Licensed Clinical Psychologist must check box(es) below and complete comment section to indicate why member is being referred for ABA services.

☐ Tantrum Behavior	☐ Deficits in Safety Awareness	☐ Communication Deficits
☐ Aggression	☐ Deficits in Self-Help Skills	☐ Deficits in Social Interaction
☐ Self-Injurious Behavior	☐ Skill Acquisition	☐ Restrictive, Repetitive Patterns of Behavior
☐ Self-Stimulatory Behavior	☐ Property Destruction	
☐ Elopement	☐ Poor Executive Functioning	☐ Other (Please describe below)

Notes/Comments: (Referral reason(s) must be clearly indicated below.)