Physicians Plus

Autism Intensive Level Treatment Request

Physicians Plus Member Number: _____ Date: _____

Patient Name: _____ Patient DOB: _____

Qualified Provider Name: _____ Provider Number: _____

Clinic Name: _____ Phone: _____ Fax: _____

Treatment History

Diagnosing Provider Name: _____ Diagnosis Date: _____

Diagnosis: _____

Initial Onset Date of Intensive Level of Care: _____

Total Time at Intensive Level of Care: _____

Other Providers Involved? (please list): _____

Treatment Plan (*Include a copy of the clinic's treatment plan with this form and be sure to indicate the progress in achievement of the treatment objectives and goals.)*

Begin Date: _____ End Date: _____

Treatment Plan Requirements (the treatment plan must include the following):

- The treatment plan is developed by a qualified provider as defined in s. 632.895 (12m), Stats.
- The treatment plan includes at least 30 hours per week over a 6-month period.
- Treatment must be evidence-based behavioral intensive therapy with specific goals that are clearly defined, directly observed and continually measured that address the characteristics of autism spectrum disorders.
- Shall require the insured must be present and engaged in the intervention.
- Include training and consultation, participation in team meetings and active involvement of the insured's family and treatment team for implementation of the therapeutic goals developed by the team.
- The insured is directly observed by the qualified provider at least once every 2 months.

DO NOT WRITE BELOW THIS LINE. FOR UW BH AUTHORIZATION AND COMMUNICATION.

Axis I Dx	Criteria Met for Intensive Level of Care		Begin Date	End Date
_____	Yes_____	No_____	_____	_____

Authorization Number: _____ Consultant: _____ Date: _____

Comments: _____

_____

Return to: UW Behavioral Health, 6001 Research Park Blvd., Madison, WI 53719 Phone Number: (608) 233-3575 Fax Number: (608) 238-1026