Early Intervention Intensive Services Autism Service Request (Massachusetts Only)

Note: To bill for these services the member and the member's parent/legal guardian must be present.

Please complete all parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification.

Note: The information contained in this form may be released to the member or the member's representative.

Date of request: ____/____/____

Member name: _____ Member ID#: _____

DOB: ____/____/____ Age: _____

Note: Early Intervention services will cover the member up to the member's third birthday.

Name of Early Intervention program/provider: _____

Provider ID/NPI#: _____ Phone #: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Name of person at provider's office to notify with the decision (and phone # if different from above):

_____

Code(s) requested (check all that apply) and the frequency:

☐ H0031 Mental health assessment, by non-physician – Assessment and treatment planning by a BCBA

Average number of hours weekly: ____

☐ H0032 Mental health service plan development by non-physician – Direct supervision of paraprofessional by a BCBA

Average number of hours weekly: ____

☐ H2012 Behavioral health day treatment, per hour – Direct service by a BCBA

Average number of hours weekly: ____

☐ H2019 Therapeutic behavioral services, per 15 minutes – Paraprofessional direct service supervised by a BCBA

Average number of hours weekly: ____

Total average number of hours weekly: ____

Signature of Early Intervention professional: _____Date:____/____/____

Fax: 617.673.0314

Address: Behavioral Health Department
Tufts Health Plan
705 Mt. Auburn Street
Watertown, MA 02472