ABA Referral Form

This form is designed to meet the Department of Health Care Services (DHCS) requirement for a medical necessity recommendation for behavioral health treatment (BHT) or applied behavioral analysis (ABA) services. A physician or licensed psychologist should complete this form.

Please submit this completed form via secure link at https://gateway.cencalhealth.org/form/bh **or** by fax at (805) 681-3070.

ALL SECTIONS MUST BE COMPLETE FOR SUBMISSION AND TO BE ACCEPTED

MEMBER INFORMATION

Full Name:

D.O.B: Age: Phone Number:

Member ID: Preferred Language:

Diagnosis or Provisional Diagnosis:

EVALUATING PROVIDER INFORMATION **Only a Physician, Surgeon or Clinical Psychologist May Refer a Member for ABA*

Provider Name:

LIcense Type: ○ Primary Care Physician ○ Psychiatrist ○ Psychologist ○ Other (M.D./D.O.)

Street Address:

City: State: Zip:

Office Phone Number: Office Fax Number:

Must Answer YES in order to proceed. If you've answered ***NO*** to any of the questions, please contact BH Provider Line at (805) 562-1600 before sending.

1) Is Member under 21 years of age? ○ YES ○ NO

2) Is Member medically stable? ○ YES ○ NO

Must Answer NO in order to proceed. If you've answered ***YES*** to any of the questions, please contact BH Provider Line at (805) 562-1600 before sending.

Does Member have a need for 24 hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities? ○ YES ○ NO

Is ABA treatment assessment recommended? ○ YES ○ NO

Has family/caregiver chosen a BHT/ABA Agency? ○ YES ○ NO Provider Name:

If no, refer to BH Call Center at (877) 814-1861 or cencalhealth.org to identify a preferred provider before sending.

Provider Signature: Date:

This recommendation is good for 6 months from the date of signature.

***For providers with questions**, contact the Behavioral Health Provider Line at (805) 562-1600*

***For members with questions**, contact the Behavioral Health Call Center at (877) 814-1861*