EIBI Service Checklist and Information Sheet

Member Information		
Name:	DOB:	Member ID/Plan:
Provider Information		
Billing Address:	Tax ID:	NPI:

Contacts for this request (preferably two contacts – insurance rep and/or LABA)	
Name:	Name:
Email:	Email:
Phone:	Phone:

Please select which service you are requesting today, and make sure all components are submitted with your request.

Assessment ☐

☐ The Member has a confirmed diagnosis of Autism Spectrum Disorder (DSM-5-TR) conferred by a physician or licensed psychologist.

☐ The Member has a diagnosis of Down Syndrome from a licensed Physician who is qualified to make such a diagnosis, and the diagnosis is confirmed by genetic testing.

Initial Services ☐

☐ Individual Family Service Plan (IFSP) with EIBI indicated

☐ Assessment completed by a Licensed Applied Behavior Analyst (LABA)

☐ Treatment plan (with baseline data for all goals) and requests for units

If you did not previously request and receive authorization for assessment of this Member, please also include:

☐ Confirmed diagnosis of Autism Spectrum Disorder (ASD), conferred by a physician or licensed psychologist

☐ Diagnosis of Down Syndrome from a physician who is licensed and qualified to make such a diagnosis, and the diagnosis is confirmed by genetic testing

Concurrent Services (continued services) ☐

☐ Treatment plan (should always include initial baseline, current progress, and previous data as applicable)

Additional units for an active authorization ☐

☐ Clinical rationale with supporting data for your request

☐ Clear statement of units being requested and new total units for authorization

TPL (Member has a different primary funder)

☐ TPL is covering services, and we are requesting a secondary authorization from MBHP for copays and deductibles.

☐ Authorization letter or statement of authorized units and date of service needed. This must include Auth # or person spoken to at TPL insurer.

- If EIBI is not covered, please send that letter EVERYTIME.
- If a Member's primary does not require prior auth, please send documentation of that EVERYTIME.

☐ Use Checklist above for what needs to be submitted based on your type of request.

☐ TPL has denied EIBI coverage

☐ Denial letter

☐ Use checklist above for what needs to be submitted based on your type of request.

Service/Units Being Requested		
97151 – TL	Assessment/Re-assessment	Units:
H0031 – TL	Case Planning/Care Coordination	Units:
97155 – TL	Direct Supervision/Direct LABA (will need rationale)	Units:
97153 – TL	Direct Instruction	Units:
97156 – TL	Parent training	Units:
97157 – TL	Group Parent Training	Units: