Physicians Plus
INSURANCE CORPORATION

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 20 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: ______________________

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Return to: UW Behavioral Health, 6001 Research Park Blvd., Madison, WI 53719 Phone Number: (608) 282-8960 Fax Number: (608) 238-1026