Initial Referral Request for Applied Behavior Analysis

This resource is provided as a guide and courtesy only. Providers are not required to use this resource; however, failure to provide the necessary clinical information may result in delays and/or termination of authorized care. For complete guidance on the requirements, please reference TRICARE Operations Manual, Chapter 18, Section 3.

As part of the Autism Care Demonstration (ACD), TRICARE requires a complete referral prior to enrollment in the ACD. The referral must include a definitive Autism Spectrum Disorder (ASD) diagnosis with level of severity/support, DSM-5 checklist (Attachment A), Validated Assessment Tool (VAT), and a request for Applied Behavior Analysis (ABA).

Beneficiary Last Name:	Beneficiary First Name:
Beneficiary DoD Benefit #:	Beneficiary DOB (MM/DD/YYYY):

Note: *If the beneficiary is the dependent of an Active-Duty Service Member, the beneficiary must be registered in the Extended Care Health Option (ECHO) Program.*

Referring Provider *(name and credentials)*:	
Tax ID/NPI:	
Initial ASD Diagnosis Date (MM/DD/YYYY):	Symptom Severity Level:
Medical/Psychological Co-Morbidities:	

TRICARE-authorized PCMs and specialized ASD diagnosing providers, board-certified or board-eligible in:

- ☐ Child psychiatry
- ☐ Child neurology
- ☐ Pediatrician
- ☐ Developmental behavior pediatrics
- ☐ Neurodevelopmental pediatrics
- ☐ Doctor of Nurse Practice (DNP)*
- ☐ Doctoral-level licensed clinical psychologist
- ☐ Family medicine physicians
- ☐ Pediatric or family nurse practitioners

**For DNPs credentialed as developmental pediatric providers, dual American Nurses Credentialing Center (ANCC) board certifications are required as follows: 1) either a pediatric NP or a family NP; and 2) either (Family, or Child/Adolescent) Psychiatric Mental Health Nurse Practitioner (PMHNP) or a (Child/Adolescent) Psychiatric and Mental Health Clinical Nurse Specialist (PMHCNS).*

Validated Assessment Tool (VAT) completed:

Please submit VAT completed and signed by the diagnosing provider in addition to completing the below fields

- ☐ Autism Diagnostic Interview – Revised (ADI-R)
- ☐ Autism Diagnostic Observation Schedule (ADOS-2)
- ☐ Gilliam Autism Rating Scale – Third Edition (GARS)
- ☐ Screening Tool for Autism in Toddlers and Young Children (STAT)
- ☐ Childhood Autism Rating Scale – Second Edition (CARS2)

Date VAT Completed (MM/DD/YYYY):	Please Indicate score of VAT:

Note: *If the beneficiary was first diagnosed with ASD at age eight years or older, then a specialized ASD diagnosing provider evaluation is required.*

AUTISM CARE DEMONSTRATION

Is Applied Behavior Analysis (ABA) therapy recommended? ☐ Yes ☐ No

Name of preferred ABA provider *(if applicable)*:

Signature of Referring Provider:	Date (MM/DD/YYYY):
Co-Signature of Referring Provider:	Date (MM/DD/YYYY):

Please submit this form via the secure provider portal on Availity or via fax at 877-875-9037.