Behavioral Framework™

REFERRAL FORM

Select Service Type:* Autism Diagnostic Evaluation ABA Therapy

Testing Location (Diagnostic Services Only):*

Boone Cary Charlotte Greenville High Point Wilmington

Date of Referral:* ______________________ **Parents aware of referral:*** Yes No

Client Information

Client Name:* ______________________ **Date of Birth:*** ______________________

Street Address:* ______________________

City:* ______________ **State:*** ______________ **Zip:*** ______________

Caregiver/Parent Name(s):* ______________________

Contact Number(s):* ______________________ **Email:*** ______________________

Caregiver type:* Biological Parent Legal Guardian Foster Parent Other: __________

Is the child in DSS custody?* Yes No

DSS Caseworker Name: ______________________ **Caseworker Contact #:** ______________

Insurance Information

Primary Insurance:* ______________________ **Member ID:** ______________________

Secondary Insurance: ______________________ **Member ID:** ______________________

Referral Information

Referring Provider:* ______________________ **NPI:** ______________________

Practice Name:* ______________________

Fax Number:* ______________________ **Callback Phone:*** ______________________

Purpose of Referral

Diagnostic testing to rule out/confirm Autism

Please send the following information with the referral to avoid issues with insurance preauthorization:

- Encounter Summary/Clinical Notes — detailing presenting symptoms warranting testing
- Copy of previous testing assessment/reports (documentation of diagnosis/date received)

ABA Therapy Referral (Child has a confirmed F84.0 Autism Spectrum Disorder diagnosis)

Please send the following information with the referral to avoid issues with insurance preauthorization.

- Copy of diagnostic evaluation for Autism & related encounter form/visit note(s).

To Return: **Fax:** (980) 206-0991 **Email:** intake@behavioralframework.com