Applied Behavior Analysis (ABA)

# Supervision via Telehealth Request & Attestation

**For any questions, call Blue Cross and Blue Shield of Montana (BCBSMT) at 855-313-8909 or BCBSMT FEP at 877-885-3751. Fax Form to 855-649-9681. Instructions: Please complete this form to have your request reviewed.**

## PROVIDER INFO

Provider/Agency Name ______________________ NPI ____________ Request Submission Date _____/_____/________

BCBA Supervisor Name ______________________ NPI ____________ Professional Level ____________________

Provider resident state ____________ Has the Provider met state practice regulations/requirements? ☐ Yes ☐ No

Services conducted in same state? ☐ Yes ☐ No

## PATIENT INFO

Patient Name ______________________ Date of Birth ____________ Request Submission Date ____________

Subscriber Name ______________________ Subscriber ____________________ Group ____________________

## TELEHEALTH REQUIREMENTS

☐ Provider/BCBA has/will be submitted clinical documentation so a determination for medical necessity for this member for ABA services has been/can be made.

☐ Provider/BCBA can provide documentation to support that this member is in a rural Health Professional Shortage Area (HPSA), or this member meets the standards for telehealth supervision outlined in the Applied Behavior Analysis and Telehealth Supervision document.

☐ Provider/BCBA has/will be been informed of their rights and responsibilities regarding this requested service and member written consent specific to participation in telehealth supervision has been obtained.

☐ Provider/BCBA has written protocols to ensure telehealth supervision meets state/federal laws, established member care standards and privacy and confidentiality (HIPAA) standards regarding electronic record transmission.

☐ Provider/BCBA has availability of high quality video/audio equipment, up to date security software, and real time interactive connectivity using internet-based conferencing software programs.

☐ Provider/BCBA has written protocols for management of urgent/emergent situations.

☐ Provider/BCBA will maintain timely, complete records of all telehealth services provided to member.

☐ Provider/BCBA will arrange for the functional assessment every six months to be 'face to face' for quality treatment planning to occur.

## ATTESTATION

I ______________________ plan on providing ABA supervision via telehealth to BCBSMT member ______________________ starting _____/_____/________. I have read the document titled Applied Behavior Analysis and Telehealth Supervision and meet all requirements for delivery of these supervision services via telehealth. I attest by my signature below that my professional license and practice meets all state, federal laws and criteria. I understand that it is my responsibility to comply with all BCBSMT, state & federal telehealth regulations and guidelines. I hereby certify that my representations contained in this document are true and accurate. I further understand that any information entered on this attestation document that is subsequently found to be false could result in termination of any agreement I have or entered with BCBSMT.

I understand and agree that, as a part of the process for delivery of telehealth services, I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and/or experience, clinical competence, telehealth requirements or standards that must be met, or any other criteria used by BCBSMT for determining initial and ongoing eligibility participation for these services. I acknowledge that the information obtained relating to this process will be held confidential to the extent permitted by law.

ABA Supervisor Signature:______________________ ABA Supervisor Printed Name: ______________________

Date: _____/_____/________ Clinic Name: ______________________

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