BlueCross BlueShield of Oklahoma

Applied Behavior Analysis (ABA)

Supervision via Telehealth Request & Attestation

For any questions, call Blue Cross and Blue Shield of Oklahoma (BCBSOK) at 800-672-2378 or BCBSOK FEP at 877-906-6389.
Fax Form to 877-361-7660. 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 BCBSOK 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 BCBSOK, 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 BCBSOK.

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 BCBSOK 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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