P.O. Box 459089
Fort Lauderdale, FL 33345-9089

# Primary Care Provider Acknowledgement and Care Coordination Behavior Analysis Services Form

**Purpose:** This form must be signed by the member's Primary Care Provider (PCP) to confirm their awareness that Behavior Analysis (BA) services have been requested or are ongoing for a member and that the PCP has been given an opportunity to identify relevant medical, behavioral, developmental, medication, safety, or care coordination considerations. This acknowledgement is intended to support care coordination and does not replace the BA provider's assessment, treatment plan, required clinical documentation, or the health plan's medical necessity review. This form must be submitted along with the BA Prior Authorization Request.

## 1. Member Information

**Member Name:** _____
**Member Medicaid ID:** _____
**Date of Birth:** _____
**Health Plan:** _____
**Caregiver / Guardian / Parent Name:** _____
**Caregiver / Guardian / Parent Phone:** _____

## 2. PCP Practitioner Information

**PCP / Practitioner Name:** _____
**Practice Name:** _____
**National Provider Identifier (NPI):** _____
**Phone:** ___ **Fax:** _____ _____
**Email / Secure Contact:** _____

## 3. BA Provider Information

**ABA Provider / Agency Name:** Aspire Behavioral Care
**Lead Analyst Name:** _____
**Lead Analyst Credential:** ☐ BCBA ☐ BCaBA ☐ Licensed Practitioner ☐ Other: _____
**Provider Contact:** 321-451-1668
**Requested Authorization Period:** _____
**Requested Service Intensity:** _____ week or _____ units/week

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**4. PCP Acknowledgement**

Please check all that apply:

- ☐ I am aware that BA services have been requested for this member.
- ☐ I have received or reviewed information indicating that the member has a behavioral, developmental, or functional need for evaluation and/or treatment through BA services.
- ☐ I understand that the BA provider / lead analyst is responsible for completing the behavior assessment, developing the behavior treatment plan, monitoring progress, and recommending the clinically appropriate service intensity.
- ☐ I understand that the health plan is responsible for reviewing the authorization request and making a medical necessity determination based on required documentation.
- ☐ I am not being asked to determine the number of BA hours, approve the BA treatment plan, or replace the role of the lead analyst.

By signing below, I acknowledge that I have been informed of the member's request for or receipt of BA services and have had the opportunity to provide relevant care coordination information. My signature does not constitute approval of the BA treatment plan, service intensity, or authorization request. Authorization decisions remain subject to health plan medical necessity review and applicable Medicaid coverage requirements.

**PCP / Practitioner Signature:** _____

**PCP / Practitioner / Group Printed Name:**

_____

**Date:** _____

**NPI:** _____