



Brief Intake to Determine Funding Coverage

“Developing Skills, Improving Behavior, Changing Lives”

Parents/Guardians,

In order for us to contact your health care provider, to determine eligibility and obtain authorization for in-network or single-case agreements, we will need the following information:

Patient Full Name: _____ DOB: _____

Your child will need a diagnosis with a CPT code between 299.0-299.9. This has to be provided by a licensed professional (*not a school employee*) and should be based upon a thorough assessment. Typically this is done by a Developmental Pediatrician, Licensed Clinical Psychologist or Mental Health professional. On the report there will be a statement about the child’s diagnosis. ABA services funded by the insurance companies through the state mandate requires a diagnosis of Autism Spectrum Disorder, Aspergers, PDD, Rett’s syndrome and anything between 299.0 to 299.9.

_____ Autism _____ Aspergers _____ PDD NOS _____ Other

Patient Primary Street Address: _____

City: _____ State: _____

Zip: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Sponsor Name: _____ Ph. Number: _____

Sponsor Date of Birth: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company: _____

Sponsor Name: _____ Ph. Number: _____

Sponsor Date of Birth: _____

*You may fax this information back to us at 850-521-1973; scan it and email it to us at bmcservices@bmcsoutheast.com; or put it in regular mail to our office in Tallahassee at 1406 Hays St. Suite 8, Tallahassee, Florida 32301
Once we have the above information we will be able to check for eligibility for ABA services from your insurance company.*