kind
BEHAVIORAL HEALTH

Applied Behavior Analysis Service Order / Referral Form

Please fax the completed referral form to (919) 467-6777 and attention "KBH Intake Team". If you have any questions, feel free to contact our Intake Team directly at intake@kindbh.com.

Patient Information

Patient's Full Name	
Patient's Date of Birth (mm/dd/yyyy)	
Patient's Street Address	
City/ State/ Zip	
Patient's Phone Number	
Patient's E-Mail Address	
Does Patient have an F84.0 ASD Diagnosis?	0 Yes 0 No
Date of Diagnosis (mm/dd/yyyy)	
Diagnostic Severity Level (Per DSM-5 Diagnostic Criteria)	0 **Level 1:** Requiring Support 0 **Level 2:** Requiring Substantial Support 0 **Level 3:** Requiring Very Substantial Support

Referring / Ordering Provider Information

Referring/Ordering Provider Name	
Name of Practice	
Provider's Phone Number	
Provider's Fax Number (optional)	
Practice Street Address	
City/ State/ Zip	
Provider's NPI	

Referring/Ordering Provider Signature and Credentials: ______________________________

Date: ______________________________

**** **Per the Medicaid Clinical Policy (CCP-BF):** "A Licensed Medical Doctor (MD), Licensed Doctor of Osteopathic Medicine (DO), or Licensed Psychologist according to their scope of practice shall complete and sign a service order. Each service order must be signed and dated by the authorizing professional and must indicate the date on which the service was ordered."*

INSURANCE COVERAGE