Prescription for ABA services

Client's Name: _____DOB: _____

Primary Diagnosis:_____

Secondary Diagnosis: _____

Authorization Period 40 hours per week for 12 months unless otherwise specified below.

Hours 10, 20, 30, or 40 Months: 6 or 12
Please Circle Please Circle

I, _____, find the above patient to be an appropriate candidate for the above specified number of hours of ABA therapy per week. I find the services to be beneficial and medically necessary.

Physician Information

Name: _____NPI #: _____

Clinic Address: _____

Signed: _____ Date: _____