OPTUM | Maryland

Clinical Confirmation Form (CCF)

Instructions: This document is required for confirmation of an Autism Spectrum Disorder (ASD) diagnosis. The form is necessary ONLY in the following circumstance:

- Participant was *younger than 3.0 years old* at time of ASD diagnosis; **AND**
  2 years or more has passed since the participant was diagnosed with ASD

Please complete the following checklist and include a copy of the visit summary dated within the last 6 months from date of form completion to confirm whether the participant continues to meet criteria for ASD diagnosis and requires ABA services.

Name of Medicaid Participant:____ **Date of Birth:**__________________

Date of most recent face to face evaluation *(must be within the past 6 months):*_______________________________

Please complete the following: *(a response for each section is required)*	Check one:		
	Yes	No	N/A
I am one of the following, with the training and experience to diagnose Autism Spectrum Disorders (ASD): Pediatrician or Developmental Pediatrician / Pediatric Neurologist Child Psychiatrist / Clinical Psychologist Nurse Practitioner / Neuropsychologist			
I have attached a copy of my most recent face-to-face evaluation completed with this participant and his/her parent or caregiver within the past 6 months.			
Based on my history, direct observation of the participant, and review of any relevant records, he/she continues to meet criteria for a diagnosis of Autism Spectrum Disorder (ASD).			
If this participant has been receiving Applied Behavior Analysis (ABA) services, I have reviewed his/her progress and response to intervention.			
I recommend that this participant receive ABA services.			
This participant has social communication deficits and/or maladaptive behaviors directly attributable to ASD for which ABA is a medically necessary intervention. Please list: ______ ______________________ ______________________			

Please provide any additional information relevant to this participant's diagnosis and need for ABA services:

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I attest that I am the qualified health care professional providing care for this Medicaid participant and the medical necessity information contained in this document is true, accurate and complete, and to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Printed Name:________________________Signature:__________________________________Date:_____________