Autism Spectrum Progress Report – confidential
Please Fax to: 262-754-9690, Attn: Claims Department

For more information on Autism Spectrum Disorder benefit and coverage limitations, please call CGHC Member Services at 877-514-2442 or visit www.CommonGroundHealthcare.org/Current-Members/coc

Provider: Please select level of service: **Intensive Service Level** ______ **Non-Intensive Service Level** ______

Demographics

Patient's Name:			D.O.B.		Sex:	______	Male	______	Female
Member ID #:		Provider Name:							

History/Background

Medical Diagnosis (es)		Mental Health Diagnosis (es)	

When was patient diagnosed with Autism?	Date:		Who made the diagnosis?		Provider name/phone #	

For services being requested, where is the care being provided (day care, etc.)? Please explain:

Do the parent(s) work outside the home? ☐ Yes ☐ No; Other ________________
If so, how many days per week and hours per day.______

What Treatment has the patient been receiving to date: (please complete below)

Provider Name:	**Dates of service: Start/Finish**	**What services were provided? How involved were the parents?**	**How often?**	**If a gap in service, please explain.**

Has this patient received any services through the waiver program? ☐No ☐ Yes; please explain:

Assessment

What types of therapies are currently being requested? (In Home, Play Therapy, Speech, etc.)

1) ______
2) ______
3) ______
4) ______
5) ______

How is progress measured?

What is the prognosis of the current treatment approach? (based on?)