



Autism Spectrum Disorder Benefit Questionnaire

Patient's Name:
Patient's Member ID:
Date of Birth:

Group Number:
Group Name:

If above information is not correct, please note this on the form or contact us.

Please answer the following questions in relation to the above noted patient, and provide additional information where applicable.

1. Has the patient been formally diagnosed with any of the following?

- Autism
- Asperger's syndrome
- Pervasive development delay not otherwise specified

Comments: _____

2. If so, when was he/she diagnosed (Month/Year)?

3. If the patient is already being treated for one of the above diagnoses, when did the treatment begin? (Month/Year)

4. Who is the treating provider (supervising the care)? Please list provider name, address or location and phone number.

If other providers are being seen regularly, please list them as well.

5. Was a treatment plan written by the treating provider and if so, when? If unknown, we can contact the provider as long as the information is listed above.

Please see other side to complete/sign.

Today's Date: _____

Name of person completing this form – Name, Relationship to Patient and Phone Number:

This form can be completed and faxed directly back to Dean Medical Affairs Department, Attn: Case Management, #608-836-6516, or mailed to Dean Health Plan, Attn: Case Management, 1277 Deming Way, Madison, WI 53717.

Thank you for your time!

Completion by DHP Staff Only:

- Coverage Effective Date:**
- Confirmed Diagnosis: Y/N**
- Obtained Treatment Plan: Y/N**
- Age of Child: 2-9, 10+**
- Plan Provider Supervising: Y/N**
- Comments:**