ABI - NEW YORK – SUPERBILLS

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ACHIEVE BEYOND
Pediatric Therapy & Autism Services

538 Broadhollow Road, Suite 202
Melville, NY 11747
P: 631-385-7780
F: 646-839-5789
E: ABIBilling@achievebeyondusa.com
Tax ID: 32-0313700

Insurance:

Aetna

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (per visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Follow-up Assessment-servere PB (per 30 min.)	0362T/0363T	
Direct ABA by BCBA (per 30 min.)	0364T/0365T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Direct Supervision-severe PB (per 30 min.)	0373T/0374T	
Family Training (per visit)	0370T	☐
Social Skills Group (per visit)	0372T	☐
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Insurance:

Aetna

Date of Service: _____ **Start Time:**_____:_____**AM/PM**

End Time:_____:_____**AM/PM**

Patient Name: _____ **Rendering Provider:** _____ **Location: Home or Clinic**

*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	
	Note: Checkbox = ☐	

1 unit = 30 minutes

Ex: 2.5 hours = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____

***Include Credentials**

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Insurance:

Beacon HealthFirst

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Follow-up Assessment-servere PB (per 30 min.)	0362T/0363T	
Direct ABA by BCBA (per 30 min.)	0364T/0365T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Direct Supervision-severe PB (per 30 min.)	0373T/0374T	
Family Training (per visit)	0370T	☐
Social Skills Group (per visit)	0372T	☐
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Insurance:

Beacon HealthFirst

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
**Include Credentials

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Tax ID: 32-0313700

Insurance:

CIGNA

Date of Service: _____ **Start Time:**_____:_____**AM/PM**

End Time:_____:_____**AM/PM**

Patient Name: _____ **Rendering Provider:** _____ **Location:** **Home or Clinic**
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Direct ABA by BCBA (per 30 min.)	0368T/0369T	
Direct/Indirect Supervision (per hour)	G9012	
Family Training w/o child (per 1 hour visit)	0370T	
Social Skills Group (per 1 hour visit)	0372T	
		☐
		☐
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Insurance:
CIGNA

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
*Include Credentials

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Tax ID: 32-0313700

Insurance:

Empire BCBS

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Follow-up Assessment-servere PB (per 30 min.)	0362T/0363T	
Direct ABA by BCBA (per 30 min.)	0364T/0365T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Direct Supervision-severe PB (per 30 min.)	0373T/0374T	
Family Training (per visit)	0370T	☐
Social Skills Group (per visit)	0372T	☐
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

Empire BCBS

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Insurance:

FIDELIS

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	HOURS/UNITS
Assessment (per hour)	H0031	
Direct Supervision (per hour)	G9012	
Indirect Supervision (per hour)	H0032	
Social Skills Training (per 15-min.)	H2014	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 15 minutes
Example: 2.5 hour long session = 10 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Insurance:

FIDELIS

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic

*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 15-min.)	H2019	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 15 minutes
Example: 2.5 hour long session = 10 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____

***Include Credentials**

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Insurance:

United-Oxford-OPTUM

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic

*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	HOURS
Assessment (per hour)	H0031	
Direct Supervision (per hour)	H0032	
Indirect Supervision (per hour)	H0031	
Direct ABA (per hour)	H2012	
Team Meeting (per hour)	H2012	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____

*Include Credentials

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Insurance:

United-Oxford-OPTUM

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 15 min. unit)	H2019	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 15 minutes
For example: 2.5 hours session = 10 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
*Include Credentials

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Tax ID: 32-0313700

Insurance:

Value Options Empire NYSHIP

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Direct ABA by BCBA (per 30 min.)	0368T/0369T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Family Training (per 30 min.)	0370T	
Social Skills Group (per 30 min.)	0372T	
Group Family Training (per 30 min)	0371T	☐
		☐

Cancelled by Provider (PA)	☐
Cancelled by Family (CA)	☐

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

Value Options-Empire(NYSHIP)

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

1 unit = 30 minutes
Ex: 2.5 hours = 5 units

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
*Include Credentials

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F: 646-839-5789
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Tax ID: 32-0313700

Insurance:

Value Options-GHI

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	UNITS
Assessment (per 15 min.)	H0031	
Direct Supervision (per 15 min.)	S5108	
Family Training (per 15 min.)	S5110	
Indirect Supervision (per 15 min.)	H0032/H0031	
Team Meeting (per 15 min.)	G9012	
Social Skills Group (per 15 min.)	H2014	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐

1 unit = 15 minutes
Example: 2.5 hour long session = 10 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

Value Options-GHI

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 15-min.)	H2019	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Note: Checkbox = ☐
1 unit = 15 minutes
Example: 2.5 hour long session = 10 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

PRIVATE PAY - ABA

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	HOURS
Assessment	BA019	☐
Supervision (Indirect/Direct/Team Meeting)	BA005	
ABA Therapy by BCBA	BA003	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

Check Box

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Pediatric Therapy & Autism Services

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Tax ID: 32-0313700

Insurance:

PRIVATE PAY - ABA - HOME

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	HOURS
ABA Therapy by BT (per hour)	BA018	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
*Include Credentials

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Tax ID: 32-0313700

Insurance:

PRIVATE PAY - ABA - CLINIC

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	HOURS
ABA Therapy by BT (per hour)	BA017	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
*Include Credentials

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Tax ID: 32-0313700

Insurance:

PRIVATE PAY - SPEECH

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic
*Please circle one

Subscriber ID: _____

FOR SLP USE ONLY	CODES	Check Boxes
Evaluation	TE015	☐
30 Minute Speech/Language Session	TP036	☐
45-Minute Speech/Language Session	TP037	☐
60-Minute Speech/Language Session	TP035	☐
Cancelled by Provider (PA)		☐
Cancelled by Family (CA)		☐

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Speech-Language Pathologist: _____ **Speech-Language Pathologist:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

Value Options OSCAR

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Patient Name: _____ **Rendering Provider:** _____ **Location:** Home or Clinic

*Please circle one

Subscriber ID: _____

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Direct ABA by BCBA (per 30 min.)	0368T/0369T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Family Training (per 30 min.)	0370T	
Social Skills Group (per 30 min.)	0372T	
Group Family Training (per 30 min)	0371T	☐
		☐

Cancelled by Provider (PA)	☐
Cancelled by Family (CA)	☐

Note: Checkbox = ☐

1 unit = 30 minutes

Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____

***Include Credentials**

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P: 631-385-7780
F: 646-839-5789
E: ABIBilling@achievebeyondusa.com
Tax ID: 32-0313700

Insurance:

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Location: **Home** or **Clinic**
*Please circle one

Value Options OSCAR

Patient Name: _____ **Rendering Provider:** _____

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

1 unit = 30 minutes
Ex: 2.5 hours = 5 units

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

538 Broadhollow Road, Suite 202
Melville, NY 11747
P: 631-385-7780
F: 646-839-5789
E: ABIBilling@achievebeyondusa.com
Tax ID: 32-0313700

Insurance:

Value Options HIP

Patient Name: _____

Subscriber ID: _____

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Rendering Provider: _____ **Location:** Home or Clinic
*Please circle one

FOR BCBA USE ONLY	CPT CODE	VISITS/UNITS
Behavior Identification Assessment (2hr. visit)	0359T	☐
Follow-up Assessment-observational (per 30 min.)	0360T/0361T	
Direct ABA by BCBA (per 30 min.)	0368T/0369T	
Direct Supervision-adaptive behavior (per 30 min.)	0368T/0369T	
Family Training (per 30 min.)	0370T	
Social Skills Group (per 30 min.)	0372T	
Group Family Training (per 30 min)	0371T	☐
		☐

Cancelled by Provider (PA)	☐
Cancelled by Family (CA)	☐

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**

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Tax ID: 32-0313700

Insurance:

Date of Service: _____ **Start Time:**_____:_____AM/PM

End Time:_____:_____AM/PM

Location: Home or Clinic
*Please circle one

Value Options HIP

Patient Name: _____ **Rendering Provider:** _____

Subscriber ID: _____

FOR BT USE ONLY	CPT CODE	UNITS
ABA Therapy by BT (per 30-min.)	0364T/0365T	
Cancelled by Provider (PA)	☐	
Cancelled by Family (CA)	☐	

1 unit = 30 minutes
Ex: 2.5 hours = 5 units

Note: Checkbox = ☐
1 unit = 30 minutes
Example: 2.5 hour long session = 5 units

SESSION ACTIVITIES

PROGRESS TOWARDS OUTCOMES (INCLUDE DATA)

ADDITIONAL NOTES

Parent/Guardian Name: _____ **Parent/Guardian Signature:** _____

Behavior Therapist Name: _____ **Behavior Therapist Signature:** _____

Supervising BCBA Name: _____ **Supervising BCBA Signature:** _____
***Include Credentials**