CLINICAL RECORDS REQUEST TEMPLATES

Records Request — Diagnosing Clinician

The letter your team sends when the family does not have the evaluation. Send it with a signed release attached.

Date _____ **Our reference** _____

To (clinic / clinician) _____ **Fax or secure email** _____

Client name _____ **Client date of birth** _____

LETTER

To the medical records department:

Our practice has been asked to provide applied behavior analysis services to the client named above. A signed authorization to release information is attached. We are requesting the following records for the purpose of establishing eligibility and preparing a request for authorization to the client's health plan:

- The comprehensive diagnostic evaluation, including the diagnosing clinician's name, credentials, and signature
- The date of the evaluation and the diagnostic instruments administered, with scores
- The diagnosis and severity level as documented
- Any written referral, order, or prescription for behavioral services
- Any related psychological, developmental, or speech and language testing

Please send records to [FAX NUMBER] or [SECURE EMAIL]. If any portion is unavailable, a note telling us so is genuinely useful — it tells us to stop waiting and to arrange the evaluation another way. Questions can go to [STAFF NAME] at [PHONE].

Requested by _____ **Title** _____

Practice _____ **Phone** _____

CLINICAL RECORDS REQUEST TEMPLATES

Fax Cover Sheet

Records still move by fax in this field. Keep a cover sheet with a confidentiality notice on it.

To	**Fax number**
From	**Return fax**
Date	**Pages including this one**
Re (client initials and DOB only)	**Callback number**

MESSAGE

CONFIDENTIALITY NOTICE

This transmission is intended only for the person or entity named above and may contain information that is confidential and protected by law. If you are not the intended recipient, any disclosure, copying, distribution, or action taken in reliance on it is prohibited. If you received this in error, please notify us immediately at [PHONE] and destroy the transmission.

> Put only the minimum identifying information on a cover sheet. Client initials and date of birth are usually enough to route it.

CLINICAL RECORDS REQUEST TEMPLATES

Referral & Order Request — Primary Care Physician

For the states and plans that gate the benefit on a physician referral or written order rather than the diagnosis.

Date _____ **To (physician / practice)** _____

Fax or secure email _____ **Client name** _____

Client date of birth _____ **Health plan** _____

LETTER

Dear Dr. [NAME],

Your patient named above has been referred to our practice for applied behavior analysis services. The patient's health plan requires a referral and written order from the treating physician before an authorization request can be submitted. A signed authorization to release information is attached.

Please complete and return the order below, along with the most recent diagnostic evaluation and any related testing in your records. Returning it promptly is the single thing that most shortens the wait before this child can start.

ORDER — TO BE COMPLETED BY THE PHYSICIAN

Diagnosis and ICD-10 code _____ **Date of diagnosis** _____

Diagnosing clinician (if not you) _____ **Instrument used, if known** _____

- ☐ I refer this patient for an applied behavior analysis assessment and, if medically necessary, treatment.
- ☐ I have reviewed the patient's history and consider these services medically necessary.
- ☐ A copy of the diagnostic evaluation is attached.

Physician signature _____ Printed name and credential _____ Date _____

NPI _____ Practice _____ Phone _____

CLINICAL RECORDS REQUEST TEMPLATES

Diagnosis Confirmation — Short Form

For programs that accept a signed statement of the diagnosis in place of a full evaluation. Never a substitute where the plan asks for the evaluation itself.

Client name _____ **Date of birth** _____

CLINICIAN STATEMENT

I am a [PHYSICIAN / LICENSED PSYCHOLOGIST / OTHER QUALIFIED PROFESSIONAL] licensed in [STATE]. I have evaluated the client named above and confirm the following diagnosis, established on the date shown, using the instrument and criteria indicated.

Diagnosis and ICD-10 code _____ **Date established** _____

Instrument(s) administered _____ **Severity level documented** _____

Date most recently reconfirmed _____ **Evaluation on file at** _____

I understand this statement may be submitted to the client's health plan in support of a request for authorization of applied behavior analysis services.

Clinician signature _____ Printed name and credential _____ Date _____

License number and state _____ NPI _____ Phone _____

> Recency windows differ by state and plan — six months in some programs, three to five years in others. Record the date the diagnosis was established and the date it was last reconfirmed, because a plan may accept one and not the other.