

Provider Referral Information

In home ABA services for children and young adults ages 1 to 21

Golden State Spectrum provides individualized, evidence-based Applied Behavior Analysis services throughout Los Angeles County. We coordinate with families, physicians and related providers to help each referred client move from benefit verification to assessment and treatment as efficiently as possible.

SERVICES

- In-home ABA therapy
- Comprehensive BCBA assessments
- Individualized treatment planning
- Parent and caregiver training
- Behavior support and skill development
- School and provider collaboration

WHEN TO REFER

- Autism diagnosis or ongoing diagnostic evaluation
- Communication, social or adaptive skill needs
- Challenging behavior affecting daily life
- Need for caregiver training and structured support
- Difficulty with routines, transitions or independence

REFERRAL PROCESS

1	2	3	4
Submit referral Fax the referral form and supporting records.	Family contact We contact the family and verify benefits.	Assessment A BCBA completes the authorized assessment.	Treatment start Services begin after plan authorization.

INSURANCE PLANS

Aetna | Anthem Blue Cross | Blue Shield of California | Carelon Behavioral Health | TRICARE West

Coverage, eligibility, network participation and authorization requirements vary by member and plan. Our team verifies benefits before services begin.

SEND REFERRALS

Fax 800-298-1563

Questions 747-600-1100

4605 Lankershim Blvd., Suite 609

North Hollywood, CA 91602

goldenstatespectrum@gmail.com

Patient Referral Form

Please fax this form and relevant clinical records to 800-298-1563

PATIENT AND FAMILY

Patient name _____	Date of birth _____
Parent or guardian _____	Relationship to patient _____
Primary phone _____	Email _____
Home address _____	Preferred language _____

INSURANCE

Insurance plan _____	Member ID _____
Subscriber name _____	Subscriber date of birth _____
Secondary insurance _____	Secondary member ID _____

CLINICAL INFORMATION

Diagnosis and date diagnosed _____
Reason for referral and priority concerns _____
Current services including speech OT school or behavioral support _____
Safety communication or behavioral concerns _____

REFERRING PROVIDER

Provider name and credentials _____	Practice or organization _____
Phone _____	Fax _____
Email _____	NPI if applicable _____
Signature _____	Date _____

Requested supporting documents Diagnosis or evaluation report | Recent clinical notes | Insurance card copies | Prior authorization if available

Privacy notice This form may contain protected health information. Transmit it only through an approved secure method. Do not email completed patient information to the general email address. Include parent or guardian authorization to exchange information when required.