WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190
608-977-5000

Autism Spectrum Progress Report
CONFIDENTIAL

Please indicate level of service: ◯ Intensive Service Level ◯ Non-Intensive Service Level

Member Information

Subscriber ID:	Group ID:
Member First Name:	Member Last Name:
Member DOB:	Gender: ◯ Male ◯ Female

Provider Information

Provider First Name:	Provider Last Name:	
Provider NPI:	Tax ID:	
Clinic Name:	Clinic Address:	
City:	State:	ZIP:
Clinic Phone:	Clinic Fax:	

History/Background

Medical Diagnosis(es):	Mental Health Diagnosis(es):

When was member diagnosed with Autism?

What provider made the diagnosis?

First Name: Last Name: Phone:

How was the diagnosis made? List specific tools used or referenced in making the determination.

Specific symptoms (including duration and intensity) associated with Autism Spectrum diagnosis:

Where does the member spend the majority of his/her day (day care, parent(s), relatives, school, etc.)?

Autism Spectrum Progress Report

What treatment did the member receive to date?

Provider Name:	Start Date of Service:	End Date of Service:
What services did the member receive? How were the parent(s) involved?		
How often did the member receive services? If a gap in service, please explain.		

Provider Name:	Start Date of Service:	End Date of Service:
What services did the member receive? How were the parent(s) involved?		
How often did the member receive services? If a gap in service, please explain.		

Provider Name:	Start Date of Service:	End Date of Service:
What services did the member receive? How were the parent(s) involved?		
How often did the member receive services? If a gap in service, please explain.		

Did this member receive any services through the waiver program? ◯ Yes ◯ No
Please explain:

Is this member on the waiting list for the waiver program? ◯ Yes ◯ No
How long?

What was done while on the waiver waiting list?

Did the parent(s), primary care givers, teachers complete a written and/or oral assessment of their concerns regarding this family member? ◯ Yes ◯ No
Details:

Autism Spectrum Progress Report

Assessment		
What primary concerns/issues will you address?		
What is the degree of language impairment?		
What is the degree of cognitive impairment?		
Are any non-specific behavioral disorders present? (Ex: eating, sensory, tolerance for pain, eye contact, etc.)		
What are the current stressors in this member's life? (Ex: divorce, separation, death in the family, loss of pet, etc.)		
How do you determine if the member is making progress?		
How do you measure the progress?		
When do you try a new approach/therapy?		
How do you determine the prognosis of the current treatment plan?		
Medication: Dosage:	Medication: Dosage:	Medication: Dosage:
Medication: Dosage:	Medication: Dosage:	Medication: Dosage:
When do you plan to stop treatment? Who will review the care and how often?		

When complete, please return this form to:

WPS Employee Group Members:
WPS Health Plan
Attn: Integrated Care Management
P.O. Box 1229
Madison, WI 53701-1229
Phone: 800-977-7178 | Fax: 608-226-8016

All other Members:
WPS Health Insurance
Attn: Integrated Care Management
P.O. Box 8190
Madison, WI 53708-8190
Phone: 800-333-5003 | Fax: 608-226-4777