HEALTH NET
FEDERAL SERVICES
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TRICARE®

Autism Care Demonstration Diagnostic Assessment

Definitive Diagnosis Referring Provider Attestation

This attestation is specific to TRICARE West Region beneficiaries enrolled to the Autism Care Demonstration (ACD) prior to Oct. 1, 2021, and can only be completed by TRICARE-authorized autism spectrum disorder (ASD)-diagnosing or referring providers. Applied behavior analysis (ABA) providers are not permitted to complete this attestation or the DSM-5 Diagnostic Criteria Checklist.

Beneficiary's Full Name: ______________________________ Sponsor ID/DBN: _______________ Beneficiary's Date of Birth: ________________

STEP 1

I am the:

- ☐ Referring provider (referred the beneficiary for existing ABA services or will refer for renewing ABA services)
- ☐ ASD-diagnosing provider currently managing the beneficiary's care

Name: ______________________________

NPI: ______________________________

Phone Number: ______________________________

Civilian or Military Clinic Name: ______________________________

TRICARE-authorized primary care manager:

- ☐ family practice physician
- ☐ internal medicine physician
- ☐ pediatric nurse practitioner
- ☐ pediatric physician

TRICARE-authorized specialty ASD-diagnosing provider, board-certified or board-eligible in:

- ☐ developmental behavioral pediatrics
- ☐ neurodevelopmental pediatrics
- ☐ child neurology
- ☐ child psychiatry
- ☐ doctoral-level licensed clinical psychologist
- ☐ Doctor of Nursing Practice

Validated Assessment Tool Completed:

- ☐ Screening Tool for Autism in Toddlers and Young Children (STAT)
- ☐ Autism Diagnostic Observation Schedule (ADOS)
- ☐ Autism Diagnostic Interview (ADI)
- ☐ Childhood Autism Rating Scale (CARS)
- ☐ Gilliam Autism Rating Scale (GARS)*

* If the GARS-3 was completed, a diagnostic evaluation demonstrating the diagnosing provider used other methodology to supplement the parent questionnaire to render a diagnosis is also required.

Date Validated Assessment Tool Completed: ______________________________

Comment box:

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STEP 2

Please complete the DSM-5 Diagnostic Checklist on page 2. TRICARE requires a completed DSM-5 Diagnostic Checklist for beneficiaries who entered into the Autism Care Demonstration prior to Oct. 1, 2021, at their next referral cycle and each two-year referral renewal. Your completion of this checklist in advance will help ensure this requirement is met.

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DSM-5 Diagnostic Checklist

TRICARE requires a completed DSM-5 Diagnostic Checklist for beneficiaries who entered into the Autism Care Demonstration (ACD) prior to Oct. 1, 2021, at their next referral cycle and each two-year referral renewal. The DSM-5 Diagnostic Checklist identifies the level of support required according to DSM-5 autism spectrum disorder (ASD) criteria.

Beneficiary's Full Name: ______________________ Sponsor ID/DBN: ____________ Beneficiary's Date of Birth: ____________

DSM-5 Criteria	Autism Spectrum Disorder		
Please note: For individuals who have a well-established DSM-5 diagnosis of ASD, Asperger's disorder or PDD-NOS, please check this box and complete the below checklist to reclassify the previous diagnosis to ASD.	☐		
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (all three must be met):	**Present**	**Not Present**	
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.	☐	☐	
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.	☐	☐	
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.	☐	☐	
Social communication domain severity rating (check one): **(1)** Requires Support **(2)** Substantial Support **(3)** Very Substantial Support *Note: See DSM-5 page 52 for severity description.*	☐ **1**	☐ **2**	☐ **3**
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history:	**Present**	**Not Present**	
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).	☐	☐	
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat samefood every day).	☐	☐	
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed orperseverative interests).	☐	☐	
4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).	☐	☐	
Restricted, repetitive behaviors domain severity rating (check one): **(1)** Requires Support **(2)** Substantial Support **(3)** Very Substantial Support *Note: See DSM-5 page 52 for severity description.*	☐ **1**	☐ **2**	☐ **3**
	Yes	**No**	
C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).	☐	☐	
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.	☐	☐	
E. These disturbances are not better explained by intellectual disability or global developmental delay.	☐	☐	
Autism Spectrum Disorder Criteria Met?	☐ **Yes**	☐ **No**	
With or Without Intellectual Impairment?	☐ **With**	☐ **Without**	
With or Without Language Impairment?	☐ **With**	☐ **Without**	
Known Comorbid Conditions: **(1)** Medical/genetic/neurodevelopmental diagnosis **(2)** Mental/behavioral diagnosis **(3)** Other	☐ **1**	☐ **2**	☐ **3**
Date of Diagnosis	☐		

Provider Name ______________________ Signature ______________________ Date ____________

How to Submit: Civilian providers and military hospitals and clinics: Fax BOTH pages to our ACD-dedicated fax line at 1-877-910-0945.

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