Child's Name: _____

I authorize Lighthouse Autism Center to act on my behalf for the limited purpose of requesting and submitting a continuity of care request, including any necessary supporting documentation, to Anthem/Carelon Medicaid. This authorization allows Lighthouse Autism Center to communicate with Anthem/Carelon Medicaid regarding my child's ABA therapy services and the medical necessity of care. I understand this authorization is specific to continuity of care and may be revoked by me at any time in writing.

Parent/Guardian Name: _____

Signature: _____

Date: _____

[redacted]