



**Magellan Behavioral Health of Pennsylvania, Inc.  
Managing Care for Pennsylvania HealthChoices  
Bucks, Cambria, Lehigh, Montgomery, and Northampton Counties**

**Consent to Receive Text Message Appointment Reminders**

**Please fill out all parts of this form and email to [textconsent@magellanhealth.com](mailto:textconsent@magellanhealth.com), or fax to:**

If you are a Bucks or Montgomery County member: 866-667-7744

If you are a Lehigh or Northampton County member: 866-382-1258

If you are a Cambria County member: 866-667-7744

Your aftercare following a hospitalization is important to your health. By signing this paper, you give Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) your OK to send you text message reminders with the appointment date, appointment time when available, provider, and location of your first appointment. Magellan does not charge any fees to send texts, but your data plan might do so. To stop the texts, you can text the word "STOP" to cancel at any time.

**Cell Phone # (Include Area Code) to Receive Text Messages:** \_\_\_\_\_

Member's Last Name: \_\_\_\_\_ Member's First Name: \_\_\_\_\_

Member's Medical Assistance ID #: \_\_\_\_\_ Member's Date of Birth: \_\_\_\_\_

Member's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Check One:  I am the member, **OR**  I have the legal right to act for this person.

Check One: I'm his/her  Parent **OR**  Guardian, **OR**  Other: \_\_\_\_\_

I give my **OK** to receive text messages with the date and location of my first follow up appointment after leaving the hospital. I understand that text messages cannot be sent securely and can be seen by anyone who uses my phone. If I lose my phone or change my number, I will tell Magellan.

\_\_\_\_\_  
Signature or Mark of Member Date

**Authorized Representative** means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If you are signing on behalf of the member, complete the below section. **If the member is less than 18 years old**, a parent or guardian must sign below, in addition to the minor.

\_\_\_\_\_  
Signature of Authorized Representative Date

Printed Name of Authorized Person: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Full Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

If you have questions, please contact Magellan at:

Bucks County 877-769-9784	Cambria County 800-424-0485	Lehigh County 866-238-2311	Montgomery County 877-769-9782	Northampton County 866-238-2312
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Members who are hearing impaired can reach us by using PA Relay 7-1-1.