Magellan Behavioral Health of Pennsylvania, Inc.
Interested IBHS Provider Information Application

Please complete the following form if your agency is seeking to be added to Magellan HealthChoices network of IBHS providers. Please type your responses to the questions below and submit the additional documents listed below.

Provider Name: ______________________________

Street Address: ______________________________

City: ______________________ State: ________ Zip: ________

Contact Name: ______________________ Contact Phone Number: ______________________

Is your agency IBHS licensed? ☐ Yes ☐ No (if no, please hold)

Is your agency Medical Assistance (MA) enrolled? ☐ Yes ☐ No

If MA enrolled, please provide MA #: ______________________________

Does your agency have a Clinical and Administrative Director in place who currently meets the PA IBHS regulation requirements?

☐ Yes ☐ No

Does your agency have a HIPAA compliant medical record keeping system? ☐ Yes ☐ No

How many members are currently being served at your agency? ______________________

How many Medicaid Magellan members are you planning to serve at your agency? ______________________

How many of your agency's current members have Magellan as secondary coverage? ______________________

Which third party liability (TPL) insurers is your agency currently contracted with?

____

Please detail organizational structure including responsible parties for billing, quality, compliance, packet submission, etc.

____

Does your agency's approved Service Description currently reflect the proposed services you are requesting contract for?

☐ Yes ☐ No

If you have answered "no" to any of the yes/no questions above, please do not submit this form and the additional documents listed below until all items are in place first.

If you have answered "yes" and answered all the questions above, please submit the following documents in addition to this form to MBHInterestedProviderApplication@magellanhealth.com.

- Copy of agency IBHS license
- IBHS Program Description & State Approval Letter
- Resumes of IBHS Clinical Director and IBHS Administrative Director
- QM Plan
- IBHS Licensing Program Information form (specific to each service provided)
- IBHS Licensing Survey Tool (Specific to each service provided)

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***** MBH Personnel Only *****

Received Date: ______________________ Date of Scheduled Provider Meeting: ______________________

Notes: ____

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