



Magellan Behavioral Health of Pennsylvania, Inc.
HealthChoices Treatment Authorization Cover Sheet for
Individual & ABA Intensive Behavioral Health Services (IBHS)

Type of Request: Please check off the type of request being submitted and indicate the submission method (Availability or Fax) by selecting the appropriate option below.

Via Availability: ☐ Pre-Service Request ☐ Concurrent Service Request If Availability was not used, please explain: _____
Via Fax: ☐ Change of Prescription ☐ 1-30 Day Administrative Extension Request ☐ Auth Transfer Request ☐ Stop Current Auth/Start New Request
☐ Pre-Service Request without a known provider ☐ Data Entry Request ☐ Error Correction Request

<input type="checkbox"/>	Bucks County	<input type="checkbox"/>	Cambria County	<input type="checkbox"/>	Lehigh County	<input type="checkbox"/>	Montgomery County	<input type="checkbox"/>	Northampton County		
Member Name:				MA ID #:				Date of Birth (MM/DD/YYYY):			
Provider Name:				Magellan Provider MIS #:				Packet Contact:			
Authorization Information					Assessment Recommendations						
Services Being Requested	Auth Codes	Total Units Requested	Start Date MM/DD/YYYY <small>Start date must be within 2 business days of submission</small>	End Date MM/DD/YYYY <small>6 months maximum</small>	Hours per Month	Setting	New Service or Change in hours? <small>Currently approved hours/month if applicable</small>	Dates by Setting	Units by Setting & Dates		
Individual IBHS					Individual IBHS						
<input type="checkbox"/> BC	H0032UB						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
<input type="checkbox"/> MT	H2019UB						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
<input type="checkbox"/> BHT	H2021AH						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
							<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
							<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
ABA IBHS					ABA IBHS						
<input type="checkbox"/> BC-ABA	97151HO						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
<input type="checkbox"/> BHT-ABA	97152HO						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
	97152HO						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
	97152HO						<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> New <input type="checkbox"/> No Change Currently approved <input type="text"/> hrs./month				
DSM-5 DIAGNOSIS with ICD-10 Code						Medications					
Select all identified Social Determinants of Health (SDOH) Concerns:											
<input type="checkbox"/> Not Assessed		<input type="checkbox"/> None Known		<input type="checkbox"/> Food Insecurity		<input type="checkbox"/> Financial Instability		<input type="checkbox"/> Housing Insecurity		<input type="checkbox"/> Lack of Childcare	
<input type="checkbox"/> Medical Cost Barrier		<input type="checkbox"/> Transportation		<input type="checkbox"/> Education/Low Literacy		<input type="checkbox"/> Interpersonal Violence		<input type="checkbox"/> Social Isolation		<input type="checkbox"/> Unemployment/Underemployment	
<input type="checkbox"/> By checking this box, the provider attests that the Member has had an EPSDT screening in the past 12 months.											

Additional Information

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