Magellan HEALTHCARE℠

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 (Availity or Fax) by selecting the appropriate option below.

Via Availity: ☐ Pre-Service Request ☐ Concurrent Service Request If Availity 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

☐ Beford County	☐ Bucks County	☐ Cambria County	☐ Lehigh County	☐ Montgomery County	☐ Northampton County	☐ Somerset 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** Start date must be within 2 business days of submission	**End Date MM/DD/YYYY** 6 months maximum	**Hours per Month**	**Setting**	**New Service or Change in hours?** Currently approved hours/month if applicable	**Dates by Setting**	**Units by Setting & Dates**
Individual IBHS					**Individual IBHS**				
☐ **BC**	H0032UB						☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
☐ **MT**	H2019UB						☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
☐ **BHT**	H2021AH						☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
							☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
							☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
ABA IBHS					**ABA IBHS**				
☐ **BC -ABA**	97151HO						☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
☐ **BHT-ABA**	97152HO						☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
							☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		
							☐ Increase ☐ Decrease ☐ New ☐ No Change Currently approved ____ hrs./month		

DSM-5 DIAGNOSIS with ICD-10 Code	**Medications**

Select all identified Social Determinants of Health (SDOH) Concerns:

☐ Not Assessed	☐ None Known	☐ Food Insecurity	☐ Financial Instability	☐ Housing Insecurity	☐ Lack of Childcare
☐ Medical Cost Barrier	☐ Transportation	☐ Education/Low Literacy	☐ Interpersonal Violence	☐ Social Isolation	☐ Unemployment/Underemployment

☐ **By checking this box, the provider attests that the Member has had an EPSDT screening in the past 12 months.**

Additional Information