



Magellan Behavioral Health of Pennsylvania, Inc.
LEHIGH/NORTHAMPTON COUNTIES HEALTHCHOICES
EI BHRS TREATMENT AUTHORIZATION REQUEST

Lehigh & Northampton Counties
EI BHRS

 Initial
 Reauthorization

Date of Birth (MM/DD/YYYY): ____ / ____ / ____

Member's Name: _____

Member's MA ID #: _____

 803849000 Elywn, Inc.

 153536000 KidsPeace

Provider Phone #: ____ - ____ - ____ EXT: ____

Services Being Requested	# of Units Requested	Start Date (MMDDYY)	End Date (MMDDYY)	MAGELLAN USE ONLY					
				Outcome Code	CPT	Prob Type	Mod1	Mod2	Mod3
<input type="checkbox"/> FBA				599	H0032	001	U2	HK	
<input type="checkbox"/> Enhanced Mobile Therapy				599	H2019	001	HK	EP	
<input type="checkbox"/> Enhanced BSC, MA Level				599	H0032	001	HK	EP	
<input type="checkbox"/> Enhanced TSS				599	H2021	001	HK	EP	
ACT 62 Members									
<input type="checkbox"/> TSS In School - ACT 62				599	H2021	001	EP		
<input type="checkbox"/> BSC In School - ACT 62				599	H0032	001	HP	EP	
<input type="checkbox"/> Mand Mtg - MT - ACT 62				599	H2019	001	UA	EP	

CURRENT MEDICATION

DSM-5 DIAGNOSIS

- By checking this box, the provider requests that the Member to be placed on the Magellan BHRS Staffing Referral List.
- By checking this box, the provider attests that the Member has had an EPSDT screening in the past 12 months.
- By checking this box, the provider attests that POMs information has been submitted on www.MagellanHealth.com/provider. Please reference your Provider Handbook for additional information on completing POMS and required updates.
- By checking this box, the provider attests that they have completed and are in compliance with the Confirmation of Knowledge and Skills to Provided Applied Behavioral Analysis bulletin.
- By checking this box, the provider attests that the Attestation for Providing ABA Services has been completed and provided to Magellan.

Enter the Appropriate Dates Below:

Date of Eval (MM/DD/YYYY): ____ / ____ / ____

Date of ITM (MM/DD/YYYY): ____ / ____ / ____