Magellan Behavioral Health of Pennsylvania, Inc.
Treatment Authorization Request

☐ Bucks County ☐ Cambria County ☐ Delaware County ☐ Lehigh County ☐ Montgomery County ☐ Northampton County

Select the appropriate level of care/documentation below:

☐ Partial Hospitalization
☐ Resource Case Management
☐ Matrix Attached (ICM/BCM/RC Only)
☐ Intensive Case Management
☐ Blended Case Management
☐ Treatment Plan/Service Plan/WRAP Plan

Type of Request: ☐ Initial Request ☐ Concurrent Request

Member Name: _____ **Date:** _____

MA ID Number: _____

I. Referral Source: _____

II. Admission Date to Level of Care: _____

III. Presenting Problem (Current Behavior, Mental Status, and Risk related to functional impairment and/or dangerousness)

IV. Member's Identified Strengths (Level of responsibility for managing symptoms, ability to make choices consistent with goals, involvement in self-help/support activities, present vs. latent strengths)

V. Treatment /Service Plan, Recovery/WRAP Plan (with strengths based/measurable/objective goals, and identifying updates since previous review). Please attach copies.

VI. Progress of Treatment towards Goals (Behavioral and cognitive) (Concurrent Requests Only)

VII. Barriers to the member's improvement and/or inability to progress towards goals

What actions have been and/or will be taken to address these barriers?

Member Name: _____ **Date:** _____

VIII. Frequency of contacts with the member or attendance per week

IX. Member's substance use since last review

X. Other current supports and services involved with member (family, community, support groups, and other mental health and substance abuse services)

How is your agency collaborating with these supports and services?

XI. Current Medications, medication education provided for member and/or family, and adherence to taking medications as prescribed

Reported side effects from medication/allergies

XII. Discharge Plan and Projected Discharge Date (include mental health, substance abuse, and natural supports)

XIII. Last admissions to Acute Inpatient Hospital/Crisis Residential/Detox and reason for admission

XIV. Abnormal Involuntary Movement Scale (AIMS) completed? ☐ Yes ☐ No

XV. List labs completed

Member Name: _____ **Date:** _____

I verify that the information provided in this report is an accurate representation of member's status.

Person Completing Form	Date
Licensed Supervisor (if person completing form is unlicensed)	Date
Psychiatrist (only necessary when medications are prescribed)	Date