



**Magellan Behavioral Health of Pennsylvania, Inc.
Referral for Intensive Behavioral Health Services/
Behavioral Health Rehabilitation Services**

Bucks County Delaware County Montgomery County
 Behavioral Health Rehabilitation Services Intensive Behavioral Health Services

CURRENT PACKET MUST BE ATTACHED

Attention: Care Worker Team

PLEASE NOTE: Magellan can only make referrals for children with Act 62 benefits who are insured primarily through Pennsylvania HealthChoices. Magellan is unable to make referrals for children with Act 62 benefits through their Primary Insurance Policy.

Age: _____ Gender: M F DOB: _____ Date of Referral: _____

Initial Case Split Case Transfer Case Current Provider: _____

DSM-5 Diagnosis: _____

End Date of Current Authorization: _____

PARENT/GUARDIAN/MEMBER GAVE CONSENT FOR RELEASE OF INFORMATION:

Consent Received Date: _____

Did parent/guardian/member agree to go on the referral list? Yes No

Did parent/guardian/member complete a Magellan Authorization to Disclose form? Yes No

CONSENT MUST BE GIVEN BEFORE A PROVIDER CAN RECEIVE THE CLINICAL INFORMATION NECESSARY TO BEGIN REVIEWING THE CASE.

SERVICES THAT NEED TO BE REFERRED FOR STAFFING: BHRS ABA BHRS IBHS ABA IBHS

Behavioral Specialist Consultant Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Mobile Therapist Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Therapeutic Staff Support Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Days of the Week/Times of the Day Available for Services: _____

Member: _____ MA ID # (10 Digits): _____

Referring Agency Staff: _____ Referring Agency Phone: _____

School Contact Name (If Services in School): _____ School Contact Phone: _____

CYS Contact Name (If CYS Involved): _____ CYS Contact Phone: _____

Legal Guardian: _____ School Name: _____

Address: _____ School District: _____

City, ZIP: _____ School Address: _____

Phone: _____ School City, ZIP: _____

Legal Guardian's Email Address: _____