



**Magellan Behavioral Health of Pennsylvania, Inc.
HealthChoices Treatment Authorization Cover Sheet**

- Registration ONLY Treatment Authorization Request
 Initial Matrix Request Level of Care Assessment
 Change in BHRS Prescription

MAGELLAN USE ONLY	Initial/MIS #	Date
Reviewed By:		
Follow-Up By:		

Bucks County Cambria County Delaware County Lehigh County Montgomery County Northampton County
 Date of Birth: (MM/DD/YYYY) _____ Provider Name: _____
 Member Name: _____ Magellan Provider MIS #: _____
 MA ID #: _____ Provider Phone #: _____ Ext: _____

Services Being Requested	# of Units Requested	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	MAGELLAN USE ONLY						
				Outcome Code	CPT	Prob Type	Mod1	Mod2	Mod3	Approved?
<input type="checkbox"/> FBA				599	H0032	001	U2	HK		
<input type="checkbox"/> BSC				599	H0032	001	HP	EP		
<input type="checkbox"/> Mobile Therapy				599	H2019	001	EP			
<input type="checkbox"/> Mand Mtg - MT				599	H2019	001	UA	EP		
<input type="checkbox"/> TSS				599	H2021	001	EP			
<input type="checkbox"/> TSS Aide				599	H2021	001	HQ	EP		
<input type="checkbox"/> BHRS After school				599	H2015	001	SC	EP		
<input type="checkbox"/> Family Based Services				565	T1016	001	HR			
<input type="checkbox"/> MST				599	H2033	001	EP			
<input type="checkbox"/> FFT				599	H2019	001	HA			
<input type="checkbox"/> FFSBS				599	H0046	001	U8	SC		
<input type="checkbox"/> STAP				561	H2012	001	EP			
<input type="checkbox"/> Sub-Acute Partial				300	H0035	001				
<input type="checkbox"/> CRR Host Home / T. Foster				231	S5145	001				
<input type="checkbox"/> RTF - JCAHO				151	99221-1 unit 99231-addtl	001				
<input type="checkbox"/> RTF - Non JCAHO				200	H0019	001	EP			
<input type="checkbox"/> RTF - Non JCAHO (CISC)				252	H0019	001	HE	EP		
<input type="checkbox"/> RTF - Group Home				202	H0019	001	HQ			

ACT 62 Members (*Autism Diagnosis Required*)

<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		
<input type="checkbox"/> TSS In School - ACT62				599	H2021	001	EP			

ABA Members (*Autism Diagnosis Required*) (ACT 62 Eligible)

<input type="checkbox"/> BSC ABA (PhD/MA)				599	H0046	001	HO	HA		
<input type="checkbox"/> BSC ABA-BCBA				599	H0046	001	HO	HA	EP	
<input type="checkbox"/> TSS ABA				599	H2021	001	UB	HA		
<input type="checkbox"/> TSS ABA-RBT				599	H2021	001	UB	HA	EP	

DSM-5 DIAGNOSIS

CURRENT MEDICATIONS

- 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.MagellanProvider.com. 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.

MAGELLAN USE ONLY	Date of Eval:	/ /	Date Info Due:	/ /	Select One: ("X") <input type="checkbox"/> Initial <input type="checkbox"/> Reauthorization
	Date of ITM:	/ /	Date Info Received:	/ /	
	Date Info Requested:	/ /	Date Info Accepted:	/ /	