Magellan HEALTHCARE SM

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	Appr-oved?
☐	FBA				599	H0032	001	U2	HK		
☐	BSC				599	H0032	001	HP	EP		
☐	BSC Autism Specialty				599	H0032	001	U5	HO	EP	
☐	Mobile Therapy				599	H2019	001	EP			
☐	Mand Mtg - MT				599	H2019	001	UA	EP		
☐	TSS				599	H2021	001	EP			
☐	TSS Aide				599	H2021	001	HQ	EP		
☐	BHRS After school				599	H2015	001	SC	EP		
☐	Family Based Services				565	T1016	001	HR			
☐	MST				599	H2033	001	EP			
☐	FFT				599	H2019	001	HA			
☐	FFSBS				599	H0046	001	U8	SC		
☐	STAP				561	H2012	001	EP			
☐	Sub-Acute Partial				300	H0035	001				
☐	CRR Host Home / T. Foster				231	S5145	001				
☐	RTF – JCAHO				151	99221-1 unit 99231-addtl	001				
☐	RTF – Non JCAHO				200	H0019	001	EP			
☐	RTF – Non JCAHO **(CISC)**				252	H0019	001	HE	EP		
☐	RTF – Group Home				202	H0019	001	HQ			
	ACT 62 Members (*Autism Diagnosis Required*)										
☐	BSC In School - ACT 62				599	H0032	001	HP	EP		
☐	Mand Mtg - MT - ACT 62				599	H2019	001	UA	EP		
☐	TSS In School - ACT62				599	H2021	001	EP			
	ABA Members (*Autism Diagnosis Required*) (ACT 62 Eligible)										
☐	BSC ABA (PhD/MA)				599	H0046	001	HO	HA		
☐	BSC ABA-BCBA				599	H0046	001	HO	HA	EP	
☐	TSS ABA				599	H2021	001	UB	HA		
☐	TSS ABA-RBT				599	H2021	001	UB	HA	EP	

DSM-5 DIAGNOSIS

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CURRENT MEDICATIONS

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☐ 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.

MAGELLAN USE ONLY					Select One: ("X")
	Date of Eval:	/ /	Date Info Due:	/ /	
	Date of ITM:	/ /	Date Info Received:	/ /	☐ Initial
	Date Info Requested:	/ /	Date Info Accepted:	/ /	☐ Reauthorization