



Magellan Behavioral Health of Pennsylvania, Inc.
BUCKS COUNTY HEALTHCHOICES BHRS TREATMENT
AUTHORIZATION REQUEST

Bucks County
CQC

MAGELLAN USE ONLY	Date	Initials	MIS #
Entered:			

- Initial Reauthorization
 Change in BHRS Prescription

Date of Birth (MM/DD/YYYY): ____ / ____ / ____
 Member's Name: _____
 Member's MA ID #: _____
 Provider Phone #: ____ - ____ - ____

- 080769000 Foundations Behavioral Health 600072659 Progressions
 566862000 Child and Family Focus 117418000 Penn Foundation BHRS
 078691000 Lenape Valley Foundation
 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"/> Mobile Therapy				599	H2019	001	EP		
<input type="checkbox"/> Mand Mtg				599	H2019	001	UA	EP	
<input type="checkbox"/> BSC				599	H0032	001	HP	EP	
<input type="checkbox"/> TSS				599	H2021	001	EP		
<input type="checkbox"/> TSS Aide				599	H2021	001	HQ	EP	
ACT 62 Members (*Autism Diagnosis Required*)									
<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	
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

CURRENT MEDICATION

DSM-5 DIAGNOSIS

- 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.

Enter the Appropriate Dates Below:

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

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