Magellan HEALTHCARE SM

Magellan Behavioral Health of Pennsylvania, Inc.

DELAWARE COUNTY HEALTHCHOICES BHRS TREATMENT AUTHORIZATION REQUEST

Delaware County

EAS CQC

MAGELLAN USE ONLY	Date	Initials	MIS #
Entered:			

Date of Birth (MM/DD/YYYY): ___/___/_____

Member's Name: _____

Member's MA ID #: _____

☐ 096765000 Child Guidance Resource Center

☐ 163271000 Elwyn

Provider Phone #: ___-___-_____ EXT: _____

	Services Being Requested	# of Units Requested	Start Date (MMDDYY)	End Date (MMDDYY)	MAGELLAN USE ONLY Outcome Code	CPT	Prob Type	Mod1	Mod2	Mod3
☐	FBA				599	H0032	001	U2	HK	
☐	Mobile Therapy				599	H2019	001	EP		
☐	Mand Mtg				599	H2019	001	UA	EP	
☐	BSC				599	H0032	001	HP	EP	
☐	BSC Autism Specialty				599	H0032	001	U5	HO	EP
☐	TSS				599	H2021	001	EP		
☐	TSS Aide				599	H2021	001	HQ	EP	
	ACT 62 Members (*Autism Diagnosis Required*)									
☐	TSS In School ACT 62				599	H2021	001	EP		
☐	BSC In School - ACT 62				599	H0032	001	HP	EP	
☐	Mand Mtg - MT – ACT 62				599	H2019	001	UA	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

CURRENT MEDICATIONS

_____

_____

_____

_____

_____

_____

DSM-5 DIAGNOSIS

_____

_____

_____

_____

_____

☐ By checking this box, the provider requests that the Member to be placed on the Magellan BHRS Staffing Referral List.

☐ By checking this box, the provider attests that staffing has been secured through: _____ MIS #: _____

☐ 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.

Enter the Appropriate Dates Below:

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

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