



Magellan Behavioral Health of Pennsylvania, Inc.

Delaware County

**DELAWARE COUNTY HEALTHCHOICES BHRS
TREATMENT AUTHORIZATION REQUEST**

Change in BHRS Prescription

CQC

MAGELLAN USE ONLY	Date	Initials	MIS #
Entered:			

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

Member's Name: _____

Member's MA ID #: _____

080769000 Foundations Behavioral Health

163271000 Elwyn

096765000 Child Guidance Resource Ctr

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
<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"/> BSC Autism Specialty				599	H0032	001	U5	HO	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 MEDICATIONS

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.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): ____ / ____ / ____