Magellan Behavioral Health of Pennsylvania, Inc.
Referral for Behavioral Health Rehabilitation Services

☐ Bucks County ☐ Delaware County ☐ Montgomery County

CURRENT PACKET MUST BE ATTACHED **Attention: Care Worker Team**

Age: _____ Gender: ☐ M ☐ F DOB: _____ Date of Referral: _____

☐ Initial Case ☐ Split Case ☐ Transfer Case Current Provider: _____

DSM-5 Diagnosis: _____

_____

_____

End Date of Current Authorization: _____

PARENT/GUARDIAN/MEMBER GAVE CONSENT FOR RELEASE OF INFORMATION:

Consent Received Date: _____

Did parent/guardian/member agree to go on the referral list? ☐ Yes ☐ No

Did parent/guardian/member complete a Magellan Authorization to Disclose form? ☐ Yes ☐ No

CONSENT MUST BE GIVEN BEFORE A PROVIDER CAN RECEIVE THE CLINICAL INFORMATION NECESSARY TO BEGIN REVIEWING THE CASE.

SERVICES THAT NEED TO BE REFERRED FOR STAFFING: ☐ BHRS ☐ ABA

Behavioral Specialist Consultant Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Mobile Therapist Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Therapeutic Staff Support Hours (as prescribed in the evaluation):

Location: _____ Total Per Week: _____ Comments: _____

Days of the Week/Times of the Day Available for Services: _____

_____

_____

Member: _____ MA ID # (10 Digits): _____

Referring Agency Staff: _____ Referring Agency Phone: _____

School Contact Name
(If Services in School): _____ School Contact Phone: _____

CYS Contact Name
(If CYS Involved): _____ CYS Contact Phone: _____

Legal Guardian: _____ School Name: _____

Address: _____ School District: _____

City, ZIP: _____ School Address: _____

Phone: _____ School City, ZIP: _____

Legal Guardian's Email Address: _____