Magellan HEALTHCARE SM

Magellan Behavioral Health of Pennsylvania, Inc.

MONTGOMERY COUNTY HEALTHCHOICES BHRS TREATMENT AUTHORIZATION REQUEST

☐ **Initial** ☐ **Reauthorization**

Montgomery County

EAS CQC

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

Member's Name: _____

Member's MA ID #: _____

☐ 158922000 Central Montgomery MH Ctr ☐ 272684000 Child and Family Focus

☐ 169363000 Creative Health Services ☐ 231220000 Indian Creek Foundation

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	
☐ 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 MEDICATION

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DSM-5 DIAGNOSIS

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☐ 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): _____ / _____ / _____