PerformCARE

Child/Adolescent Services Request Submission Sheet

This form MUST be submitted with a complete request for all levels of care indicated below. **Please use Jiva Provider Portal [or fax number 1-855-707-5823] for submission of these items.**

Date: _____ Member Name: _____ MAID #: _____ D.O.B. _____

Member County: ☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

Name of Person submitting information: _____ Provider Name: _____

Phone Number: _____ Fax Number: _____

SECTION I- Authorization Requests

Request Type: ***I****=Initial* ***C****=Continuation (Re-auth)* ***T*** *= Transition*
U*=Update to Current Auth (add/increase)*

Request Type	Level of Care
	Afterschool Programs
	Assistant Behavior Consultation-ABA
	Behavior Analytic
	Behavior Consultation
	Behavior Consultation-ABA
	Behavioral Health Technician
	Behavioral Health Technician-ABA
	CRR-HH
	EIBI
	EIBS-Vista
	FBMHS ☐ Check here if Problem Sexual Behavior (PSB) or Juvenile Sex Offender (JSO)
	FFT
	Flexible Outpatient Therapy – MH-OP and MT
	IBHS Group
	IBHS Group – ABA
	IDT
	Mobile Therapy
	MST
	RTF ☐ Accredited ☐ Non- Accredited
	Stepping Stones
	YFACTS
	Other:
	Other:

SECTION II- Additional Information specifically requested by a Care Connector for an incomplete pending request.

Care Connector Name: _____

SECTION III- Additional Information specifically requested by a Care Manager

☐ Currently pending an MNC decision ☐ Information requested after an MNC decision

Care Manager Name: _____

SECTION IV- Treatment reviews

☐ FBMHS ☐ MST ☐ VISTA ☐ Other: _____

SECTION V-Miscellaneous items-routine submission not fitting criteria for Section II or III above

☐ Initial tx plan ☐ 6-month ITP Update (Note: This will not result in a medical necessity decision/authorization) ☐ Discharge Summary
☐ Transfer form ☐ Revised treatment plan ☐ Letters/correspondence ☐ Written Order Submission for IBHS Referral Process
☐ Other: _____