

### IBHS Assessment Registration Form

**(Required for provision of Behavioral Consultant (including ABA), Assistant Behavior Consultation (including ABA), Mobile Therapy, Behavior Analytic, and/or Behavioral Health Technician (including ABA) services ONLY)**

NOTE: All sections of this form must be completed or the registration will not be processed.

Member: \_\_\_\_\_

DOB: \_\_\_\_\_

Member MAID# (10 digits): \_\_\_\_\_

Member County:

- Cumberland     Dauphin     Franklin     Fulton     Lancaster     Lebanon     Perry

Provider name: \_\_\_\_\_

Person completing form: \_\_\_\_\_

Provider address: \_\_\_\_\_

Provider phone: \_\_\_\_\_

Assessment Start Date: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Date of written order/evaluation: \_\_\_\_\_

Date written order/evaluation received: \_\_\_\_\_

Recommendations

- Individual IBHS     MT     BC  
 ABA

Prescriber Name: \_\_\_\_\_

Prescriber Credentials (check one):

- Licensed physician     Licensed psychologist     LPC     CRNP     Physician Assistant     LCSW  
 LMFT

Prescriber MA Provider ID: \_\_\_\_\_

Provider NPI#: \_\_\_\_\_

(Please enter the 9-digit MA Provider #)