PerformCARE®

Flexible Outpatient Therapy for Children and Adolescents (Flex OPTx) Registration Form-IBHS

(Capital Only)

NOTE: All fields of this form must be completed prior to a Mobile Therapy (MT) authorization being generated. It is expected that copies of the written order, assessment, Individual Treatment Plan (ITP) and any additional documentation are maintained in the member chart.

Member: _____ DOB: _____

Member MAID# (10 digits): _____

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

Person completing form: _____ Phone #: _____

Date Written Order Completed: _____

Date Assessment Completed: _____

Date Individual Treatment Plan (ITP) Completed:_____

Recommendations

Mobile Therapy up to _____ hours per month

IBHS Provider to Whom MT Authorization Should Be Generated: _____

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 #)

Signatures

Signatures below indicate agreement with the provision of Flexible Outpatient Therapy for the above-named Member.

Member (14+)/Family/Guardian Signature: _____ Date: _____

MH OP Therapist Signature: _____ Date: _____

Capital Members: 1-888-722-8646
Providers: 1-888-700-7370 Fax: 1-855-707-5823
Mailing Address: 8040 Carlson Road, Harrisburg, PA 17112