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Intensive Behavioral Health Services (IBHS) Written Order Form

Today's Date: _____

Demographics

Member's Name: _____ DOB: _____

Member's Preferred Name:_____ MAID#: _____

Member's Current Address:_____

Foster Care Placement? ☐ Yes ☐ No

Current Member/Family/Guardian phone #: _____ Alternate phone #: _____

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

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Prescriber Attestation

Following my recent face-to-face appointment and/or evaluation with _____ , and after considering less restrictive, less intrusive levels of care such as _____, I am prescribing the service listed below per this IBHS Order.

It is medically necessary that _____ receive a comprehensive face-to-face assessment for Intensive Behavioral Health Services (IBHS).

Along with this written order, I have included clinical documentation to support the medical necessity of the services ordered, including a behavioral health disorder diagnosis (listed in the most recent edition of the DSM or ICD), and measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated, as per regulations.

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Clinical Information

Current Behavioral Health Diagnoses: _____

Current Medical Diagnoses: _____

Recommendations:

Intensive Behavioral Health Service Type	Specific Level of Care	Maximum number of hours per month	Setting(s) in which IBHS is necessary
☐ IBHS Individual Services	☐ Behavior Consultant (BC) ☐ Behavioral Health Technician (BHT) ☐ Mobile Therapy (MT)	Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month	☐ Home ☐ Center-based ☐ School ☐ Community, specify: _____
☐ IBHS Individual Services, Other	☐ Flexible Outpatient - Mobile Therapy (Flex-MT) ☐ Functional Family Therapy (FFT) ☐ Multi-systemic Therapy (MST)	Up to ____ hours per month Up to 90 hours per month Up to 50 hours per month	☐ Home ☐ School ☐ Community, specify: _____
☐ IBHS Individual Services, Other	☐ Youth Firesetting Assessment Consultation Treatment Services (YFACTS) ☐ Mobile Therapy (MT)	Up to ____ hours per month	☐ Home ☐ School ☐ Community, specify: _____
☐ IBHS ABA Services	☐ Behavior Analytic (BA) ☐ Behavior Consultant-ABA (BC-ABA) ☐ Assistant Behavior Consultant-ABA (Assistant BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)	Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month	☐ Home ☐ Center-based ☐ School ☐ Community, specify: _____

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☐ IBHS Group Services (Non-ABA)	☐ IBHS Group - After School Program (ASP) ☐ IBHS Group - Intensive Day Treatment (IDT) ☐ IBHS Group - IBHS Group ☐ IBHS Group - Stepping Stones	Up to _115_ hours per month Up to _200_ hours per month Up to ____ hours per month Up to 115 hours per month	
☐ IBHS ABA Group Services	☐ IBHS ABA Group - Early Intensive Behavioral Intervention (EIBI) ☐ IBHS ABA Group -Enhanced Intensive Behavioral Services (EIBS) ☐ IBHS ABA Group	Up to _161_ hours per month Up to _110_ hours per month Up to____ hours per month	

Please provide clinical information to support your recommendation and medical necessity for all services selected above: Clinical information should include the frequency, intensity, and duration of each specific behavior noted.

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Please detail all measurable improvements in targeted behaviors described above that will indicate when the services recommended may be reduced, changed, or terminated.

Prescriber Signature

Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Please indicate professional title (Must be one of these professional types):
☐ Licensed Physician ☐ Licensed Psychologist ☐ CRNP ☐ Physician Assistant ☐ LPC ☐ LCSW ☐ LMFT

MA Provider ID: _____ Provider NPI#: _____
(Please enter the 9-digit MA Provider #)

Note: All aspects of this form need to be completed or the request will not be valid.