



Magellan Behavioral Health of Pennsylvania, Inc. Children in Substitute Care (CISC) Referral Form

*****IMPORTANT: Provider must complete this in full in order for a non-par to be requested. Incomplete forms will not be processed.*****

Date of Submission: _____

Name and Credentials of Person Submitting Form: _____

Name and Credentials of Person Recommending Request: _____

Phone # and Extension of Person Submitting Form: _____

Email Address of Person Submitting Form: _____

Member Information

County of Eligibility per EVS:

Bucks Co. Cambria Co. Delaware Co. Lehigh Co. Montgomery Co. Northampton Co.

Member Name: _____

Member MA ID #: _____

Member DOB: _____

CYS Contact: _____

CYS Contact Phone #: _____

Member's CURRENT County of Residence: _____

Member's CURRENT Address/Placement: _____

Type of Placement: Foster Care TFC JPO Group Home Other: _____

Does Member have a TPL/Primary Insurance? Yes No

If yes, does the Primary Insurance cover the requested service? Yes No

Provider Information

Provider Requesting Non Par/Rendering Services: _____

Provider Address: _____

Phone #: _____

MA Enrollment #: _____

Tax ID #: _____

Fax #: _____

Requested Level of Care: BHRS IBHS Outpatient D & A PHP Other: _____

Contracting Contact Person (Provider Representative Responsible for Non Par): _____

Phone # and Extension of Contracting Contact Person: _____

Service Site Information

Address of Service Site where Treatment will be Rendered: _____

Contact Person at Service Site: _____

Phone # of Service Site: _____

Clinical Information

DSM-5 Diagnosis: _____

Current Medications: _____

Physician Providing Medication Monitoring (name/agency/contact #): _____

Treatment Goals to be Addressed: _____

Name of Primary Care Physician: _____

Primary Care Physician Phone #: _____

Services Requested

Name of Service	CPT Code	# of Units/Sessions (not to exceed 24 for OP Tx)	Start/End Date (not to exceed 6 mths)

Current Services

List all services that the member is currently receiving:

*****PLEASE NOTE*****

It is imperative that you provide the service site where the member will receive treatment. Please be aware that a non-par can only be completed for service sites that are MA enrolled. Services provided at a location that is not an MA enrolled site will not be covered by PA HealthChoices.

Please fax the completed form to the appropriate Care Manager at 866-667-7744.

Questions should be directed to the Care Manager assigned to the appropriate County by calling 877-769-9779 between 8:30 a.m. and 5:00 p.m., Monday through Friday.