

Please complete this Written Order Letter and give it to the parent/guardian, young adult (member) or the IBHS provider. After the IBHS packet is complete the written order letter, assessment, ITP and POC will be submitted to Community Care for review.

**Member Information**Child's Name: \_\_\_\_\_ DOB: (mm/dd/yyyy) MA ID #: \_\_\_\_\_ Today's Date: (mm/dd/yyyy) 

Parent/Guardian's Name(s): \_\_\_\_\_

School (if applicable): \_\_\_\_\_

Other agency involvement (if applicable): \_\_\_\_\_

Following my recent face-to-face appointment, mental health assessment or psychiatric/psychological evaluation on  DATE with \_\_\_\_\_ CHILD , and after considering less restrictive, less intrusive levels of care

such as \_\_\_\_\_ OTHER LEVELS OF CARE CONSIDERED ,  
and/or in-network evidence-based treatments including \_\_\_\_\_ EBTs CONSIDERED ,

I am prescribing the following IBH Services as per this Written Order.

It is medically necessary that \_\_\_\_\_ CHILD receives 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.

**Current Diagnoses:**

*A behavioral health diagnosis is necessary to initiate IBHS. In addition, please include other Behavioral Health and/or Physical Health diagnoses or issues of concern as applicable.*

Behavioral Health \_\_\_\_\_

Behavioral Health \_\_\_\_\_

Behavioral Health \_\_\_\_\_

Medical Conditions/  
Physical Health Issues \_\_\_\_\_Medical Conditions/  
Physical Health Issues \_\_\_\_\_Medical Conditions/  
Physical Health Issues \_\_\_\_\_



Clinical information to support the medical necessity of the service(s) ordered:

The measurable improvements in the identified therapeutic needs (for individual and Group Services) and/or in targeted behaviors or skill deficits (for ABA Services) that indicate when services may be reduced, changed or terminated:

	<b>Identified Therapeutic Needs and/or Targeted Behaviors or Skill Deficits</b>	<b>Measurable Improvements necessary to reduce, change or terminate IBH Services</b>
1.		
2.		
3.		
4.		
5.		
6.		

**Recommendation for Initial or Continued IBHS Treatment**

A comprehensive, face-to-face assessment is recommended to be completed by an IBHS clinician to further define how the recommendations in this order will be used and to inform and complete an Individualized Treatment Plan (ITP). This order is valid for 12 months. If this order needs to be amended/updated during this 12-month period, a prescriber collaboration form is to be used.

*Directions: Please select the IBHS Service Category or Categories, and the specific IBH Service Type(s) within each category that are medically necessary for the child, youth or young adult based on symptom(s) and/or behavior(s) of concern. For each service type recommended, please indicate the maximum number of hours per month (or episode if relevant) based on severity of symptoms/behaviors, and the specific setting(s) in which treatment should occur.*

*NOTE: All sections in the same row must be completed for a service to be appropriately authorized.*

Intensive Behavioral Health Service Categories <i>(select only those which correspond to the service types being recommended)</i>	IBHS Service Types	Maximum number of hours per month (hpm) <i>(NOTE: The IBHS agency may provide less as clinically indicated)</i>	Settings in which treatment is necessary
<input type="checkbox"/> IBHS Individual Services	<input type="checkbox"/> Mobile Therapist (MT) <input type="checkbox"/> Behavior Consultant (BC) <input type="checkbox"/> Behavior Health Technician (BHT)* <i>*An FBA is required first</i>	Up to _____ hpm Up to _____ hpm Up to _____ hpm	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Office Specify community location(s): _____
<input type="checkbox"/> IBHS Group Services		Up to _____ hpm	
<input type="checkbox"/> ABA Individual	<input type="checkbox"/> Behavior Analytic Services (BCBA) <input type="checkbox"/> Behavior Consultant (BC-ABA) <input type="checkbox"/> Assistant Behavior Consultant (Assistant BC-ABA) <input type="checkbox"/> Behavioral Health Technician (BHT-ABA)* <i>*An FBA is required first</i>	Up to _____ hpm Up to _____ hpm Up to _____ hpm Up to _____ hpm	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Office Specify community location(s): _____
<input type="checkbox"/> ABA Group Services		Up to _____ hpm	
<input type="checkbox"/> EBT Services	<input type="checkbox"/> Multi-systemic Therapy (MST) <input type="checkbox"/> Functional Family Therapy (FFT) <input type="checkbox"/> Parent-Child Interaction Therapy (PCIT)	Up to _____ hpm Up to _____ hpm Up to _____ hpm	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Office Specify community location(s): _____
<input type="checkbox"/> CSBBH	<input type="checkbox"/> Mobile Therapist (MT) <input type="checkbox"/> Behavior Health Technician (BHT) <input type="checkbox"/> IBHS Group Services	Up to _____ hpm Up to _____ hpm Up to _____ hpm	<input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Community <input type="checkbox"/> Office Specify community location(s): _____



**Collaboration and Confirmation**

*I confirm that following my recent face-to-face appointment and evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of in-network evidence-based treatments, I am making the recommendations as per the above Written Order.*

Prescriber's Name: \_\_\_\_\_ Degree: \_\_\_\_\_

License Type: \_\_\_\_\_ NPI#: \_\_\_\_\_ PROMISE ID#: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: (mm/dd/yyyy)

*I confirm that I have participated in the face-to-face appointment and/or evaluation (for myself/my child) and understand the above recommendations for treatment under IBHS. I understand that treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.*

Parent/Guardian's Name: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: (mm/dd/yyyy)

Youth's Name (if 14 or older): \_\_\_\_\_

Youth's Signature (if 14 or older): \_\_\_\_\_ Date: (mm/dd/yyyy)

**Help for Accessing IBH Services**

If assistance is needed to access IBH services in your area, please contact your Community Care Customer Service Representative at the number across from the county where you live.

<b>County</b>	<b>Customer Service</b>	<b>County</b>	<b>Customer Service</b>
Adams	1.866.738.9849	Lycoming	1.855.520.9787
Allegheny	1.800.553.7499	McKean	1.866.878.6046
Bedford	1.866.483.2908	Mifflin	1.866.878.6046
Berks	1.866.292.7886	Monroe	1.866.473.5862
Blair	1.855.520.9715	Montour	1.866.878.6046
Bradford	1.866.878.6046	Northumberland	1.866.878.6046
Cameron	1.866.878.6046	Pike	1.866.473.5862
Carbon	1.866.473.5862	Potter	1.866.878.6046
Centre	1.866.878.6046	Schuylkill	1.866.878.6046
Chester	1.866.622.4228	Snyder	1.866.878.6046
Clarion	1.866.878.6046	Somerset	1.866.483.2908
Clearfield	1.866.878.6046	Sullivan	1.866.878.6046
Clinton	1.855.520.9787	Susquehanna	1.866.668.4696
Columbia	1.866.878.6046	Tioga	1.866.878.6046
Elk	1.866.878.6046	Union	1.866.878.6046
Erie	1.855.224.1777	Warren	1.866.878.6046
Forest	1.866.878.6046	Wayne	1.866.878.6046
Huntingdon	1.866.878.6046	Wyoming	1.866.668.4696
Jefferson	1.866.878.6046	York	1.866.542.0299
Juniata	1.866.878.6046	En español	1.866.229.3187
Lackawanna	1.866.668.4696	TTY/TDD (Dial 711); Request	1.833.545.9191
Luzerne	1.866.668.4696		