Intensive Behavioral Health Services (IBHS) Written Order Letter

Child's Name: _____Date of Birth: _____

MA ID#:_____Today's Date:_____

Parent/Guardian's Name(s):_____

Address: _____ Phone number: _____

School (if applicable):_____

Other agency involvement (if applicable):_____

Following my recent face-to-face appointment and/or evaluation on_____ with the above child, youth and young adult and after considering less restrictive, less intrusive levels of care such as_____,
I am making the following Written Order.

It is medically necessary that the above child, youth and young adult 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.

Current Behavioral Health Diagnosis:
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 Diagnosis	Diagnosis/ICD:
Additional Behavioral Health Diagnosis	Diagnosis/ICD:
Medical conditions/physical health diagnosis	Diagnosis/ICD:

Clinical documentation to support the medical necessity of services: (include narrative)

MST is medically necessary for up to 25 hpm in home school and community settings for up to 120 days.

Measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed or terminated.

NOTE: This current page must accompany **EITHER Part A** (Initial Written Order) **OR Part B** (Written Order for Continued IBHS Treatment) to complete the Written Order

Part A: Initial Written Order for Assessment, Stabilization and Treatment Initiation

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). IBHS Treatment Services may also be delivered during the assessment period for stabilization and treatment initiation provided a treatment plan has been developed for the provision of these services.

NOTE: You must complete all sections in one row for a service to be appropriately authorized.

Intensive Behavioral Health Service Type (select only one)	**Clinician Type (clinician type must match service type)**	**Maximum number of hours per month (hpm)** NOTE: IBHS agency may provide less as clinically indicated	**Settings in which treatment is necessary**
X IBHS Individual Services	☐ Mobile Therapist (MT) ☐ Behavior Consultant (BC) ☐ Behavioral Health Technician (BHT) ☐ Multi-systemic Therapy (MST) X Multi-systemic Therapy-Psych (MST-Psych) ☐ Multi-systemic Therapy-Problematic Sexual Behavior (MST-PSB)	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to 25 hpm Up to ___ hpm	X Home X School X Community ☐ Center Based specify:
☐ IBHS Group Services	☐ School-based BH treatment ☐ Social Skills treatment ☐ Summer Therapeutic Program (STAP) ☐ PCIT ☐ ABA ☐ Other, specify:	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm	☐ If applicable, specify setting(s) other than the group service site:
☐ ABA Services	☐ Behavior Analytic Services (BA) ☐ Behavior Consultant (BC-ABA) ☐ Assistant Behavior Consultant (Asst. BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm	☐ Home ☐ School ☐ Community ☐ Center Based specify:

Part A: Initial Written Order for IBHS Assessment, Stabilization and Treatment Initiation

Collaboration and Confirmation:

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

Prescriber's Name (please print): _____Credential: _____

License Type: _____NPI#: _____PROMISE ID#: _____

Prescriber's Address: _____

Prescriber's Phone Number: _____

Prescriber's Signature: _____Date: _____

- ❑ Check that the family has received a copy of this written order.

I confirm that I have participated in the face-to-face appointment and/or evaluation, and understand the above recommendations for further assessment and if applicable, treatment initiation for stabilization under IBHS. I understand that treatment the 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 (please print): _____

Parent/Guardian's Signature: _____Date: _____

Youth's Name (if 14 or older; please print): _____

Youth's Signature (if 14 or older): _____Date: _____

For information on how to access IBHS providers, HealthChoices members please contact your county's toll-free number listed below and a Carelon Member Service Representative will be happy to assist you. Phones are answered 24 hours a day, 7 days a week.

Toll-Free County-Specific Phone Numbers:

Armstrong	877-688-5969	Indiana	877-688-5969
Beaver	877-688-5970	Lawrence	877-688-5975
Butler	877-688-5971	Mercer	866-404-4561
Crawford	866-404-4561	Venango	866-404-4561
Fayette	877-688-5972	Washington	877-688-5976
Greene	877-688-5973	Westmoreland	877-688-5977

Part B: Written Order for Continued IBHS Treatment

A comprehensive, face-to-face assessment (attached) has been completed to further define how the recommendations in this written order will be used. An Individualized Treatment Plan (attached) has also been completed, based on the result of the assessment. Please select which one of the following service types you are recommending, based on the symptom(s) and/or behavior(s) of concern and the settings/domains in which they are occurring. Please specify the IBH Service Type, the Clinician Type, the maximum number of hours per month, and the setting(s) in which treatment should occur.

NOTE: You must complete all sections in one row for service to be appropriately authorized.

Intensive Behavioral Health Service Type (select only one)	**Clinician Type (clinician type must match service type)**	**Maximum number of hours per month (hpm)** (NOTE: IBHS agency may provide less as clinically indicated)	**Settings in which treatment is necessary**
X IBHS Individual Services	☐ Mobile Therapist (MT) ☐ Behavior Consultant (BC) ☐ Behavioral Health Technician (BHT) ☐ Multi-systemic Therapy (MST) X Multi-systemic Therapy-Psych (MST-Psych) ☐ Multi-systemic Therapy-Problematic Sexual Behavior (MST-PSB)	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to 25 hpm Up to ___ hpm	X Home X School X Community ☐ Center Based specify:
☐ IBHS Group Services	☐ School-based BH treatment ☐ Early childhood treatment ☐ Social Skills treatment ☐ Summer Therapeutic Program (STAP) ☐ PCIT ☐ ABA ☐ Other, specify:	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm	☐ If applicable, specify setting(s) other than the group service site:
☐ ABA Services	☐ Behavior Analytic Services (BA) ☐ Behavior Consultant (BC-ABA) ☐ Assistant Behavior Consultant (Assistant BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)	Up to ___ hpm Up to ___ hpm Up to ___ hpm Up to ___ hpm	☐ Home ☐ School ☐ Community ☐ Center Based specify:

Part B: Written Order for Continued IBHS Treatment

Collaboration and Confirmation:

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

Prescriber's Name (please print): _____Credential: _____

License Type: _____NPI#: _____PROMISE ID#: _____

Prescriber's Address: _____

Prescriber's Phone Number: _____

Prescriber's Signature: _____Date: _____

☐ Check that the family has received a copy of this written order.

I confirm that I have participated in the face-to-face appointment and/or evaluation, 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 (please print): _____

Parent/Guardian's Signature: _____Date: _____

Youth's Name (if 14 or older; please print): _____

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