COMMUNITY CARE
Behavioral Health Organization

Intensive Behavioral Health Services (IBHS) Written Order Letter
All Counties

Please complete this Written Order Letter and give it to the parent/guardian, 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

Member Name: _____ DOB: *(mm/dd/yyyy)* _____

Chosen Name: _____ Pronouns: _____

MA ID #: | | | | | | | | | | | Today's Date: *(mm/dd/yyyy)* _____

Parent/Guardian Name(s): _____

Member address: _____ Phone Number: *(no dashes)* _____

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:

	Identified Therapeutic Needs and/or Targeted Behaviors or Skill Deficits	Measurable Improvements necessary to reduce, change or terminate IBH Services
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 *(select only those which correspond to the service types being recommended)*	**IBHS Service Types**	**Maximum number of hours per month (hpm)** *(NOTE: The IBHS agency may provide less as clinically indicated)*	**Settings in which treatment is necessary**
☐ IBHS Individual Services	☐ Mobile Therapist (MT) ☐ Behavior Consultant (BC) ☐ Behavior Health Technician (BHT)* **An FBA is required first*	Up to _____ hpm Up to _____ hpm Up to _____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based Specify community location(s): _____
☐ IBHS Group Services		Up to _____ hpm	
☐ ABA Individual	☐ Behavior Analytic Services (BCBA) ☐ Behavior Consultant (BC-ABA) ☐ Assistant Behavior Consultant (Assistant BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)* **An FBA is required first*	Up to _____ hpm Up to _____ hpm Up to _____ hpm Up to _____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based Specify community location(s): _____
☐ ABA Group Services		Up to _____ hpm	
☒ EBT Services	☐ Multi-systemic Therapy (MST) ☐ Functional Family Therapy (FFT) ☐ Parent-Child Interaction Therapy (PCIT) *(Select 1:1 Center-based for PCIT)* ☒ Multi-systemic Therapy-Psychiatric (MST-Psych)	Up to _____ hpm Up to _____ hpm Up to _____ hpm Up to 35 hpm	☒ Home ☒ School ☒ Community ☐ 1:1 Center-based Specify community location(s): _____
☐ CSBBH	☐ Mobile Therapist (MT) ☐ Behavior Health Technician (BHT) ☐ IBHS Group Services	Up to _____ hpm Up to _____ hpm Up to _____ hpm	☐ Home ☐ School ☐ Community ☐ 1:1 Center-based 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 Name: _____ Degree: _____

License Type: _____ NPI#: _____ PROMISE ID#: _____

Prescriber email address: _____

Prescriber Phone Number: *(no dashes)* _____

Prescriber 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 Name: _____

Parent/Guardian Signature: _____ Date: *(mm/dd/yyyy)* _____

Member Name (if 14 or older): _____

Member 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.

County	Customer Service	County	Customer Service
Adams	1.866.738.9849	Luzerne	1.866.668.4696
Allegheny	1.800.553.7499	Lycoming	1.855.520.9787
Bedford	1.866.483.2908	McKean	1.866.878.6046
Berks	1.866.292.7886	Mifflin	1.866.878.6046
Blair	1.855.520.9715	Monroe	1.866.473.5862
Bradford	1.866.878.6046	Montour	1.866.878.6046
Cameron	1.866.878.6046	Northumberland	1.866.878.6046
Carbon	1.866.473.5862	Pike	1.866.473.5862
Centre	1.866.878.6046	Potter	1.866.878.6046
Chester	1.866.622.4228	Schuylkill	1.866.878.6046
Clarion	1.866.878.6046	Snyder	1.866.878.6046
Clearfield	1.866.878.6046	Somerset	1.866.483.2908
Clinton	1.855.520.9787	Sullivan	1.866.878.6046
Columbia	1.866.878.6046	Susquehanna	1.866.668.4696
Elk	1.866.878.6046	Tioga	1.866.878.6046
Erie	1.855.224.1777	Union	1.866.878.6046
Forest	1.866.878.6046	Warren	1.866.878.6046
Greene	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	