Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Child/Adolescent Services Request Submission Sheet

This form MUST be submitted with a complete request for all levels of care indicated below. **If this is an Out of Network request, please submit via Fax: 1- 844-329-9100. In network providers submit via NaviNet.**

Date: _____ Enrollee Name: _____ MAID #: _____ D.O.B. _____

Enrollee County: ☐ Bucks ☐ Chester ☐ Delaware ☐ Montgomery ☐ Philadelphia

Name of Person submitting information: _____ Provider Name: _____

Phone Number: _____ Fax Number: _____

SECTION I- Authorization Requests

Request Type: ***I****=Initial* ***C****=Continuation (Re-auth)* ***T*** *= Transition*
U*=Update to Current Auth (add/increase)*

Request Type	Level of Care
	Assistant Behavior Consultation-ABA
	Behavior Analytic
	Behavior Consultation-ABA
	Behavioral Health Technician-ABA
	IBHS Group – ABA
	Other:
	Other:

SECTION II- Additional Information specifically requested by a Care Connector for an incomplete pending request.

Care Connector Name: _____

SECTION III- Additional Information specifically requested by a Care Manager

☐ Currently pending an MNC decision ☐ Information requested after a Medical Necessity decision

Care Manager Name: _____

SECTION IV-Treatment reviews

☐ FBMHS ☐ MST ☐ VISTA ☐ Other: _____

SECTION V-Miscellaneous items-routine submission not fitting criteria for Section II or III above

☐ Initial tx plan ☐ 6-month ITP Update (Note: This will not result in a medical necessity decision/authorization) ☐ Discharge Summary

☐ Transfer form ☐ Revised treatment plan ☐ Letters/correspondence ☐ Other: _____