Pennsylvania's Children's Health Insurance Program
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Coverage by Vista Health Plan,
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Intensive Behavioral Health Services (IBHS) Written Order Form

If this is an Out of Network request, please submit via Fax: 1- 844-329-9100. In network providers submit via NaviNet.

Today's Date: _____

Demographics

Enrollee's Name: _____ DOB: _____

Enrollee's Preferred Name:_____ MAID#: _____

Enrollee's Current Address:_____

Foster Care Placement? ☐ Yes ☐ No

Current Enrollee/Family/Guardian phone #: _____ Alternate phone #: _____

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

REL/SOGI (Complete each section and indicate if Enrollee preferred not to answer).

Enrollee's Race:_____ Enrollee's Ethnicity:_____

Enrollee's Sexual Orientation: _____ Enrollee's Gender Identity:_____

Enrollee's Assigned Sex at Birth:_____ Enrollee's Pronouns: _____

Enrollee's Alternative Name (if applicable): _____

Enrollee's Primary Language:

Written: _____ Spoken: _____

Prescriber Attestation

Following my recent face-to-face appointment and/or evaluation with _____ , and after considering less restrictive, less intrusive levels of care such as _____, I am prescribing the service listed below per this IBHS Order.

It is medically necessary that _____ 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.

Clinical Information

Current Behavioral Health Diagnoses: _____

Current Medical Diagnoses: _____

Recommendations:

Intensive Behavioral Health Service Type	Specific Level of Care	Maximum number of hours per month	Setting(s) in which IBHS is necessary
☐ IBHS ABA Services	☐ Behavior Analytic (BA) ☐ Behavior Consultant-ABA (BC-ABA) ☐ Assistant Behavior Consultant-ABA (Assistant BC-ABA) ☐ Behavioral Health Technician (BHT-ABA)	Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month Up to ____ hours per month	☐ Home ☐ Center-based ☐ School ☐ Community, specify: _____
☐ IBHS ABA Group Services	☐ IBHS ABA Group	Up to____ hours per month	

Please provide clinical information to support your recommendation and medical necessity for all services selected above: Clinical information should include the frequency, intensity, and duration of each specific behavior noted.

Please detail all measurable improvements in targeted behaviors described above that will indicate when the services recommended may be reduced, changed, or terminated.

Prescriber Signature

Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Please indicate professional title (Must be one of these professional types):
☐ Licensed Physician ☐ Licensed Psychologist ☐ CRNP ☐ Physician Assistant ☐ LPC ☐ LCSW ☐ LMFT

MA Provider ID: _____ Provider NPI#: _____
(Please enter the 9-digit MA Provider #)

Medical Director MA Provider ID or MA number for Clinic (for prescribers in Outpatient Clinics Only to meet ORP).

Note: All aspects of this form need to be completed or the request will not be valid.