



Magellan Behavioral Health of Pennsylvania, Inc. Interagency/Prescriber Collaboration

Bucks County Delaware County Lehigh County Montgomery County Northampton County

Member Name: _____ Date: _____

MA ID #: _____ DOB: _____

Agency: _____ Prescriber: _____

Agency Contact: _____ Phone #: _____

Summary of Interagency Team Meeting Recommendations:

Please check any relevant clinical changes that have occurred since the psychiatric/psychological evaluation or interagency team meeting that require a decrease in services:

Symptoms or behaviors have improved
Please describe:

Additional services have been initiated
Please describe:

Additional natural supports have been identified and actively engaged
Please describe:

Parental request to decrease services
Please describe:

Final (Current) Prescription of Services:

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Recommendations and Prescription for Services:

Please list all recommendations: (not only BHRSCA)

If prescription is being amended to reduce services, please explain why:

Prescriber's Signature: _____ Date: _____

Member/Family Signatures: _____ Date: _____

Current Authorization Period: _____ to _____

Date Reduction of Services Begins: _____