PerformCARE®

Intensive Behavioral Health Services (IBHS) Individual/ABA Provider Choice Acknowledgment Form

Date: _____

Member's Name: _____ MAID#: _____

Member County:

☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

IBHS Level(s) of Care prescribed in the Written Order (or Best Practice Evaluation):_____

My signature below indicates I have been provided a copy of the *Intensive Behavioral Health Services (IBHS) Provider Listing* form and made aware of all in-network providers for my/my child's County of Medical Assistance eligibility. At this time, I am choosing _____ as my IBHS provider.

NOTE: If you have primary commercial insurance and the services are for Autism Spectrum Disorder, these services may be covered under Pa. Act 62. Please check with your primary insurance for coverage and choose a provider who participates in your commercial insurance network and PerformCare

Member/Parent/Guardian Signature: _____

Printed Name: _____ Date: _____