



An AmeriHealth Mercy Company

Child/Adolescent Services
ISPT Meeting Notification - Form 11

Member Name: MAID#:

Table with 2 columns: Member County of Origin, Fax form to CBHNP. Rows include Bedford, Somerset, Blair, Franklin, Fulton, Lycoming, Clinton, Cumberland, Dauphin, Lancaster, Lebanon, Perry.

Today's Date: Meeting correction: Meeting re-scheduled Original meeting date: Meeting Date: *Time: *If an evaluation is being conducted the same day as the meeting, please indicate the start time for the meeting.

Meeting Location: Residence Agency School

Street address City PA, Zip Code

Contact Person for Meeting: Title: Provider Agency affiliated with:

Contact Person's phone #: Contact Person's fax #:

Person Facilitating Meeting: Phone # for meeting location:

Please check if the member is involved with; CYS Juvenile Probation Targeted Case Management

Meeting Type

- Initial Meeting Please check level of care, if known. TSS BSC MT ASP TAG DBI IDT CRR-HH RTF STAP MST Other:
Re-Authorization Meeting Please check level of care, if known. TSS BSC MT ASP TAG DBI IDT CRR-HH RTF STAP MST Other:
Treatment/Concurrent Review Meetings RTF/CRR-HH 30 day concurrent review FBMHS initial 30 day concurrent 45 day concurrent review 120 day concurrent review
Discharge Meeting Please check level of care, if known. TSS BSC MT ASP TAG DBI IDT CRR-HH RTF STAP MST Other:
CASSP Meeting
Other Type of Meeting, please explain reason for meeting:

CBHNP RESPONSE TO PROVIDER

CBHNP will attend in person by phone (Call 1-888-700-7370) CCM CIS

CBHNP will not attend Processed by: Date: