BHRS Packet Submission Timelines

- Initial BHRS packets should be faxed to the CAFS Coordinator within 7 calendar days from the date the treatment plan was signed.

- Ongoing BHRS packets should be faxed to the CAFS Coordinator within 7 calendar days of the ISPT meeting.

- Authorizations will be entered within 10 business days of receiving the completed packet.

- If a packet is incorrect or incomplete for any reason, the CAFS Coordinator will contact the agency that submitted the packet and indicate any corrections that are required. *This does not reset the 7 calendar day timeline for a packet to be received.*
ACT 62 Submission Guidelines

All ACT 62 information must be submitted to the BHRS ACT 62 fax line at 855-439-2441.
ACT 62 insurance verification documentation should be submitted to the Claims Liaison fax number at 855-842-1285.
The ACT 62 cover sheet is located on our website here: ACT 62 FAX Cover Sheet

If a member has a primary insurance:

1. Provider should contact the primary insurance agency to set up authorizations and billing.
2. Provider should fax a complete packet to the CAFS Coordinator. The ACT 62 fax cover sheet (located at the link above) should be completely filled out and accurate, as well as include the plan of care summary for services requested. It is suggested the ACT 62 cover sheet and plan of care summary are submitted at the time the packet is submitted.
3. Providers will receive an acknowledgement letter from VBH-PA indicating that we have received the information and that services are authorized using a service class that is not able to be billed.
4. VBH-PA will enter an authorization with a special “hold code.” Service classes for an ACT 62 authorization are:
   - AB4 for Behavioral Specialist Consultant (BSC)
   - AB5 for Therapeutic Staff Support (TSS) in the Home and Community
   - AB6 for Therapeutic Staff Support (TSS) in the School
   - MT2 for Mobile Therapy (MT)
   - FB9 for a Functional Behavioral Assessment (FBA)
5. **ACT 62 cap on primary insurance**: Providers need to check with the primary insurance to determine if the cap for benefits has been met. If the cap has been met, the provider will then resubmit to VBH-PA the current packet along with the documentation (EOB) from the primary insurance indicating that the cap has been met/exceeded.
6. VBH-PA will then pay as primary throughout the rest of the plan calendar year. Authorization will follow non-ACT 62 guidelines as along as VBH-PA is the primary payer. When the plan calendar year renews, VBH-PA will resume paying as secondary until the next cap is met.
7. If services prescribed are not a covered benefit under the primary insurance (such as primary covers BSC and TSS but does not cover MT or STAP), VBH-PA will authorize services that are not a covered benefit using the non-ACT 62 guidelines.