Magellan COMPLETE CARE

Magellan Complete Care
P.O. Box 691029, Orlando, FL 32869

Behavioral Health Prior Authorization Request Form

☐Initial Request ☐ Continued Services Request ☐Additional Units

Please complete all sections with required information and Fax to **888-656-4083.** All of the applicable information and documentation is required. Incomplete forms will be returned for additional information. You can find a list of services subject to prior authorization on our website at http://magellancompletecareoffl.com.

Request Type:	
☐Standard/Routine	
☐Expedited/ Urgent	**Must be signed by treating physician**. By signing below, I certify the standard review timeframe may seriously jeopardize the life of health of the member's ability to regain maximum function.

______________________________ ______________________________

Physician's Signature **Date Signed**

Enrollee Demographic Information:					
Last Name:		First Name, Middle Initial:		Date of Birth:	
Phone number:		Plan ID #:		Gender:	☐ Female ☐ Male
Place of residence (provide any additional contact information if applicable):					

Requesting/ Servicing Provider or Facility Information:	
Provider (if applicable):	Facility:
Address/Zip:	NPI:
Contact Person (phone and fax):	TIN:

* If this is an out-network request, please provide an explanation:

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Requested Service Information					
Setting/POS Code:	Outpatient [ ]	Inpatient [ ]	Office [ ]	Home [ ]	*Other [ ] (specify):

Diagnoses, (must include ICD 10 codes)	**HCPCS/CPT/CDT code**	**Code Description**	**Date of Service Start/End Date**	**Units**

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Additional Units request under existing authorization:
Previous Authorization number: ____________________
Start/End date of previous service: __________________ ***(End date should match current auth end date)***

Reason for requested service. Include/attach clinical information to support medical necessity.
***For initial requests, provider may attach initial assessment and treatment plan.** ***For continued stay requests, provider may attach, recent treatment plan, progress notes and/or the monthly summary notes.**

If not provided in attachment, complete the below information for all requests	
Risk of Harm (include hospitalization history):	
Functional Status (Describe current symptoms and behaviors and impact on current functioning):	
Environmental Stressors:	
Describe natural support, if available:	
Describe MH/SA Treatment History (All services tried and shown to be ineffective, if applicable):	
Describe member's self-determination to participate in treatment:	
Current psychotropic medications:	

Treatment Goals: If not provided in attachment, complete the below for all requests. Please include measurable goals. List goals for each service being requested.		
Treatment goal	**Date initiated**	**Current progress (for concurrent reviews)**

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Fill this section for ECT requests, only (if not provided in supporting documentation)	
History of previous treatment (include previous ECT) and response to treatment:	
Current Medications:	
Medical/Anesthetic Clearance:	
Provide details such as frequency, unilateral vs bilateral, etc.:	
Describe post-ECT stabilization and recovery services:	
For continued services request:	
Describe level of improvement:	
If lack of progress, how has the treatment plan changed:	
Are there any barriers to treatment at this time? If so, how are they being addressed?	
If increase in units, explain why:	

Copies of all supporting clinical information are required. Lack of clinical information may delay determination or result in adverse determination.

ATTESTATION I hereby certify and attest that all information provided as part of this prior authorization request is true and accurate.

Provider Signature: ____ **Date:** ________________________

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.