Magellan COMPLETE CARE®

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

Prior Authorization Form for Medical Procedures and Services

☐ 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
Height:		Weight:			
Place of residence (provide any additional contact information if applicable):					

☐ Same as requesting Provider

Requesting Provider Information :		**Servicing Provider/ Facility Information:**	
Requesting NPI:		Servicing NPI:	
Requesting TIN:		Servicing TIN:	
Requesting Provider Name:		Servicing Provider/Facility Name	
Contact Name, include ext.:		Contact Name, include ext.:	
Phone:		Phone:	
Fax:		Fax:	

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

_____

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Requested Medical Procedure/Course of Treatment/Device 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	Total Units/Visits/Days

***For transplant authorization requests, specify request reason, i.e. consult, evaluation, listing, actual transplant, etc.**

Reason for requested service. Include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity.	
Explain the medical reasons for requested service, including an explanation for selecting this service (s) over alternatives, if applicable:	
Treatment history (All services tried and shown to be ineffective):	
Medications (if not provided in supporting documentation):	
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.