Magellan COMPLETE CARE

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

Residential Psychiatric Treatment Authorization Request Form

☐ **Statewide Inpatient Psychiatric Program** ☐ **Therapeutic Group Care**

☐Initial Request ☐ Continued Services Request

Please complete all sections and fax to **888-656-4083.** All applicable information and documentation are 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 the treating physician**. By signing below, I certify that the standard review timeframe may seriously jeopardize the member's life or 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):					
Custody: ___ Community ___ Dependent					

Requesting/ Servicing provider or facility information:	
Provider/Facility name:	Address/Zip:
NPI:	TIN:
Contact person (name and phone #):	Fax #:

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

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Requested service information:				
Diagnoses (must include ICD 10 codes)	**HCPCS/CPT/CDT/REV code**	**Code description**	**Date of service Start date**	**End date**

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Date of last Multidisciplinary Team (MDT)/ Child and Family Staffing (CFS) meeting: ___________________
MDT/CFS recommendation: ____
Suitability assessment date and recommendation, if applicable: ___________________________________
Medical clearance for admission given: __Y/N___________ **Date**: ___________________________________

Reason for requested service. Include/attach clinical information to support medical necessity.

If not provided in attachment, complete the below information for all requests.	
Mental status exam(include SI/HI, Risk to self and others)	
Psychosocial history:	
Describe MH/SA treatment history (All services tried and shown to be ineffective, if applicable):	
History of hospitalizations:	
Current psychotropic medications: ☐ Compliant ☐ Non-Compliant	

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Discharge planning (shall begin at the time of admission) The provider shall design individualized services and treatment for the child to address the child's presenting problems on admission with a goal of discharge to the community or to a step-down program within 120 days of admission for residential treatment centers.	
Expected discharge date:	
Discharge placement/post-discharge treatment plan	☐ Home with parents with outpatient services ☐ Shelter with outpatient services ☐ BHOS ☐ Group home ☐ Home with relatives with outpatient services ☐ Therapeutic group care ☐ Foster home with outpatient services ☐ Other: ________________________________
Was the discharge date/plan changed? (If yes, explain)	
For continued services request:	
Progress toward treatment plan goals (include ETOs, PRNs, restraints, escorts):	
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?	
Family engagement:	
Home visits/passes:	
Copies of all supporting clinical information are required. Lack of clinical information may delay determination or result in an 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:** ________________________

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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 Magellan Complete Care's policy and procedures. **If you have any questions, please call us at 1-800-327-8613.**