Magellan Complete Care
PO Box 524083
Miami, FL 33152

Magellan COMPLETE CARE

Out Patient Prior Authorization Request Form
(Initial/Concurrent/Additional units)
Continuity of Care for Services authorized prior to enrollment with MCC Yes/No

Provider Instructions:
Please complete all sections with required information and Fax to **888-656-4894 (FAX)**

Request Type:
☐ **Routine**
☐ **Urgent/ Expedited**

IMPORTANT NOTE: An **Urgent/ Expedited** request is defined as a request that waiting for a decision under the routine timeframe **could place the member's life, health, or ability to regain maximum function in serious jeopardy.**

1. Enrollee Demographic/Medical Information:

Enrollee Name: _____

Member #: _____

Date of Birth: _____

Does enrollee reside in an Assisted Living Facility (ALF)?
_____

If yes, please indicate name/phone# of facility_____

2. Provider/Facility Information:

Provider/Facility Name/Tax Id#: _____

Address/Zip: _____

Contact Person: _____

Phone #: _____

Fax #: _____

Requested Start Date: _____

Requested End Date: _____

3. Requested Level/Service: (level of care, units, previous authorization number)

☐ **TBOS – HO Units: HN Units: HM Units:**

☐ **Targeted/Intensive Case Management Units:**

☐ **Psychosocial Rehab Units:**

☐ **Behavioral Health Day Treatment Units:**

☐ **Electroconvulsant therapy (ECT):**

☐ **Additional Units under the following authorization:**

4. Reason for requested service and Anticipated Length of Stay (referral source, why now)?

5. Clinical Diagnosis (all five axis):

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

6. Mental Status Exam and Risk Assessment (e.g. suicidal, homicidal, plan):

7. Medications (physical and behavioral): [include dosage & frequency]

8. Psychosocial Summary (abuse/neglect, cultural, legal, substance abuse):

9. School / Work Experience (grade, special ed, absenteeism, suspension/expulsion):

10. Current providers and supports:

Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	

11. Strengths:

12. Goals (behavior-based as stated on Treatment or Service Plans) Please include multiple goals for multiple requests:

13. Barriers/Weaknesses:

14. Discharge plan: