Magellan Complete Care: Fax Cover Sheet

FAX: 1-888-656-4894

Please provide the information below in legible print. This will assist us in processing your fax request in a more efficient and timely manner . Thank you.

Request for Authorization ☐ **Medical Records** ☐

☐ **Florida Medicaid Transition of Care** ☐

Other ☐

_____

Requestor/Contact Information

Requestor Name: _____

Facility Name: _____

Direct Contact Telephone Number: _____ Fax Number: _____

Member Information

Fax information sent pertains to: **Inpatient** ☐ **Outpatient** ☐ BH ☐ PH ☐

Name (Last Name, First Name): _____

Date of Birth: _____ Member Number / Medicaid ID: _____

Diagnosis Code: _____ CPT Codes: _____

Please be sure to attach any clinicals

NOTE: A Fax Processing Form MUST be submitted along with each patient/member request. We Strongly advise you NOT to combine multiple patient/ member requests into one fax. Doing so will cause a delay in processing your requests.

Provider Information

Name: _____ Gender: _____ D.O.B.: _____

Individual NPI: _____ Medicaid ID: _____ UPIN/Medicare#: _____ *(If applicable)*

License No.: _____ License Type: _____ Specialty: _____

Service Address: _____ *City/State/Zip*

Phone: _____ County: _____

Billing Information

TIN: _____ Group Name: _____ *(If applicable)*

Billing NPI: _____ *(If applicable)* Billing Medicaid ID: _____ *(If applicable)*

Billing Address: _____ *City/St./Zip*