



**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: \_\_\_\_\_ Billing Medicaid ID: \_\_\_\_\_  
(If applicable) (If applicable)  
 Billing Address: \_\_\_\_\_  
City/St./Zip

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