Magellan COMPLETE CARE®

Medicare Behavioral Health Authorization Request Form

Please complete all sections.

MAGELLAN COMPLETE CARE OF ARIZONA, INC. (HMO SNP)

Member Information:
Full Name: _____
Address: _____
Telephone #: (_____)_____ DOB: ____/____/_____Medicaid #: _____Medicare #:_____
Primary Insurance Name (COB): _____
Primary Insurance ID and effective date: _____

Request Type: ☐ Concurrent ☐ Standard/Routine ☐ Expedited*	***Expedited service** request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as one of the other options.*
Behavioral Health Services: ☐ Inpatient Mental Health Hospitalization ☐ Substance Use Disorder Inpatient Rehabilitation (Detox does not require prior authorization) ☐ ECT	☐ rTMS ☐ Partial Hospitalization ☐ Psychological / Neuropsychological Testing ☐ Out of Network Services ☐ Other:

Diagnosis Code and Description: _____
CPT/HCPCS Code and Description: _____
Number of Visits Requested: _____ DOS From: ____/____/____ To: ____/_____/____

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION

Requesting Provider:	**Servicing Provider:**
Name: _____	Name: _____
NPI #: _____TIN#: _____	NPI #: _____TIN#:_____
Medicare ID: _____	Medicare ID: _____
Address:_____	Address: _____
Telephone #: _____	Telephone #:_____
Fax #: _____	Fax #:_____
Contact Name/Phone #:_____	Contact Name/Phone #:_____

Submitted by:	**Date**: (MM/DD/YYYY)	**Phone Number:**

MCC of AZ (HMO SNP) Member Services Phone: 1-800-424-4509
Behavioral Health UM Fax: 1-888-656-2598