

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:

Name: _____
 NPI #: _____ TIN#: _____
 Medicare ID: _____
 Address: _____
 Telephone #: _____
 Fax #: _____
 Contact Name/Phone #: _____

Servicing Provider:

Name: _____
 NPI #: _____ TIN#: _____
 Medicare ID: _____
 Address: _____
 Telephone #: _____
 Fax #: _____
 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

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