

Medicare Medical Prior Authorization Request Form

COMPLETE ALL SECTIONS OF THIS FORM. INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

PLEASE FAX COMPLETED FORMS TO 1-888-656-2390.

MAGELLAN COMPLETE CARE OF ARIZONA, INC. (HMO SNP)		
Fax:	Date Form Completed/Faxed:	
Authorization Type		
<input type="checkbox"/> In-Network <input type="checkbox"/> Out of Network	Urgency: <input type="checkbox"/> Expedited* <input type="checkbox"/> Standard <input type="checkbox"/> Concurrent <input type="checkbox"/> Retrospective <small>* Please request "expedited" when applying the standard timeframe for making the determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.</small>	
Service Type Requiring Authorization (check all that apply)		
Ambulatory/Outpatient Services <input type="checkbox"/> Surgery/Procedure (SDC) <input type="checkbox"/> Infusion or Oncology Drugs	Ancillary <input type="checkbox"/> Acupuncture <input type="checkbox"/> Chiropractic <input type="checkbox"/> IVF/ART <input type="checkbox"/> Non-Participating Specialist	Dental <input type="checkbox"/> Adjunctive Dental Services <input type="checkbox"/> Endodontics <input type="checkbox"/> Maxillofacial Prosthetics <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Restorative
Durable Medical Equipment <input type="checkbox"/> Prosthetic Device <input type="checkbox"/> Purchase <input type="checkbox"/> Renal Supplies <input type="checkbox"/> Rental	Home Health/Hospice <input type="checkbox"/> Home Health <small>(Please circle: SN, PT, OT, ST, HHA, MSW)</small> <input type="checkbox"/> Hospice <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Respite Care	Inpatient Care/Observation <input type="checkbox"/> Acute Medical/Surgical <input type="checkbox"/> Long-term Acute Care <input type="checkbox"/> Acute Rehab <input type="checkbox"/> Observation Skilled Nursing Facility (Select level): <input type="checkbox"/> LTC <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III
Nutrition/Counseling <input type="checkbox"/> Counseling <input type="checkbox"/> Enteral Nutrition <input type="checkbox"/> Infant Formula <input type="checkbox"/> Total Parental Nutrition	Outpatient Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Pulmonary/Cardiac Rehab <input type="checkbox"/> Speech Therapy	Transportation <input type="checkbox"/> Non-emergent Ground <input type="checkbox"/> Non-emergent Air
Other—please specify:		
Provider Information (*Denotes required field)		
*Requesting Provider Name/NPI#:	*Phone:	Fax:
*Servicing Provider Name/NPI# (and Tax ID if required):	*Phone:	Fax:
<input type="checkbox"/> Same as Requesting Provider		
*Contact Person:	*Phone:	Fax:
Member Information (*Denotes required field)		
*Patient Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	*DOB: (MM/DD/YYYY)
*Health Insurance ID#:	*Patient Account/Control Number:	
<i>If other insurance, please specify:</i>		
Address:	Phone:	

Diagnosis/Planned Procedure Information (<i>*Denotes required field</i>)	
*Principal Diagnosis Description: ICD-10 Codes:	*Principal Planned Procedure (Description and CPT/HCPCS Code): # of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage
Secondary Diagnosis Description: ICD-10 Codes:	Secondary Planned Procedure (Description and CPT/HCPCS Code): # of Units Being Requested: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Visits <input type="checkbox"/> Dosage
*Service Start Date:	*Service End Date:

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