

Medicare Medical Prior Authorization Request Form

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

| 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 * 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. | |
| 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 (Please circle: SN, PT, OT, ST, HHA, MSW) <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): <input type="checkbox"/> <i>Same as Requesting Provider</i> | *Phone: | Fax: |
| *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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