Magellan COMPLETE CARE

Medicare Behavioral Health Authorization Request Form

Please complete all sections.

MAGELLAN COMPLETE CARE OF VIRGINIA, LLC (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 VA (HMO SNP) Member Services Phone: 1-800-424-4495

Behavioral Health UM Fax: 1-888-656-2621

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