

Medicare Medical Prior Authorization Request Form

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

MAGELLAN COMPLETE CARE OF VIRGINIA, LLC (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): <input type="checkbox"/> Same as Requesting Provider	*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:

****Confidentiality Notice****

This electronic message transmission contains information belonging to Magellan Health that is solely for the recipient named above and which may be confidential or privileged. MAGELLAN HEALTH EXPRESSLY PRESERVES AND ASSERTS ALL PRIVILEGES AND IMMUNITIES APPLICABLE TO THIS TRANSMISSION. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of this communication is STRICTLY PROHIBITED. If you have received this electronic transmission in error, please notify us by telephone at 1-800-424-4495. Approved Prior Authorization payment is contingent upon the eligibility of the member at the time of service. Authorization is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Thank you.