Magellan HEALTHCARE℠

**Medicaid Authorization Change Request Form**
Fax to Magellan: 1.888.656.1410

**Provider Information:**

Provider Name: _____ Date: _____

Provider MIS: _____ Phone Number: _____

Contact Name: _____

☐ Claim has been denied Date of Denial: _____

☐ Claim has not been denied

**Client Information:**

Client Name: _____ Medicaid Number: _____

Authorization Number: _____ Authorization Start Date: _____

**Change Requested:**

☐ Authorization was to incorrect service address.

Correct service address is: _____

Start date at new service address: _____

☐ CPT code on authorization letter is not what we requested.

Correct CPT code(s) is/are: _____

☐ MIS # on authorization letter is incorrect.

MIS # on authorization should be: _____

☐ Please exchange #: _____ of CPT: _____ for #: _____ of CPT: _____

When change is completed, authorization will include:

_____

_____

☐ Other. Provide description of problem on lines below:

_____

_____

_____

_____

_____

_____

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