Magellan HEALTHCARE SM

Medicaid Rehab Option (MRO)
Re-Auth Request Form
Fax to Magellan: 1.888.656.4916

Client Name as listed on Authorization: _____ **Client Date of Birth:** _____

Eligibility: Non-Medicaid Eligible: ☐ Yes SSN: _____ If Yes, please indicate Case Number: _____

Medicaid Managed Care Eligible: ☐ Yes If Yes, please indicate Member's Medicaid Number: _____

Agency: _____ **Contact Person:** _____ **Phone Number:** _____

Name and credentials of clinical contact in case further review is needed: _____

Service Address: _____ **Auth End Date:** _____

Current Diagnosis:	Current Medications (Include MAT medications):	Program Treatment Type:
		☐ Community Support
		☐ Day Rehabilitation
		☐ Psychiatric Residential Rehabilitation
		☐ ACT

Number of face to face services with the client for the month: (Community Support only) _____

Rehabilitation Need:
Measurable Goal:
Progress on Goal:

Rehabilitation Need:
Measurable Goal:
Progress on Goal:

Crisis Plan: _____

Discharge Plan and Estimated Length of Stay: _____

Any EPC's, ER visits, or Hospital Admissions since last review: ☐ Yes ☐ No **If "Yes", please list dates:** _____

Is client currently psychiatrically stable? ☐ Yes ☐ No **If "No", please briefly describe:** _____

_____

_____

Specific functional limitations related to major mental health diagnosis: _____

_____

_____