Out-of-Network Authorization Request Form

For out-of-network providers requesting a single case agreement to serve Blue Shield of California members

This form should be completed by the clinician who has a thorough knowledge of the member's current clinical presentation and his/her treatment history.

Fax the completed form to 1-888-656-3510. Questions? Call Magellan at 1-877-263-9952.

TIPS FOR COMPLETING:

- *To help expedite processing this request, complete all sections as specifically and clearly as possible.*
- *Type your responses.*
- *Do not send encrypted messages.*
- *If your request omits or generalizes information, or is illegible, we will return it to you to complete or clarify.*

Select reason for request (pick one):

☐ Transition of Care/Coordination of Care

- Non-participating providers requesting authorization of services to provide transition of care to new enrollees who have been receiving services for an acute, serious, or chronic mental health condition prior to the enrollee's change in health plan; ***or***
- For terminated (not for cause) Magellan providers seeking to continue care with a Magellan member who has been receiving services for an acute, serious, or chronic mental health condition

☐ In-Process Single Case Agreement

- Non-participating providers who are in the credentialing process and have submitted documentation to Magellan's Network Department to become a participating provider but have not yet finalized contracting terms

☐ Global Ad Hoc

- Global ad hoc providers who want to initiate care and require an authorization, or who want to request ongoing care under an existing authorization

☐ Single Case Agreement

- Initial single case agreement for services never before rendered with an out-of-network provider

Member Demographic Information:

Patient Name: Date of Birth: Age:

Subscriber Name: Member ID:

*In California, Magellan does business as Human Affairs International of California, Inc. and/or Magellan Health Services of California, Inc. – Employer Services.

Magellan OON Authorization Request on SCA
PO Box 710430, San Diego, CA 92171 **Fax** 888.656.3510
Attn: Manager, Clinical Care Services

Member Demographic Information (continued):

Address:	City/State/ZIP Code:
Language Need *(if other than English):*	Gender:

Provider/Agency/Facility Demographic Information:

Provider/Agency/Facility Name:	
NPI:	Tax ID:
Address:	License Type and Number: *
City/State/ZIP Code:	Phone:
Fax:	Email:

We are unable to authorize care to unlicensed professionals. You must have a **California license to provide care at the independent level to see our members and meet credentialing criteria.*

Describe the need for the single case agreement:

Review Type: ☐ Initial ☐ Concurrent ☐Authorization Extension
If an extension, indicate the reason:

Level of Care: ☐ Inpatient ☐ Residential ☐ Partial Hospitalization ☐ Intensive Outpatient ☐ Outpatient

Type: ☐ Behavioral Health ☐ Substance Use ☐ Eating Disorder

Delivery Method: ☐ In-Person ☐ Telehealth (Virtual)

Admission/Intake Date:	Requested Start Date of Current Authorization Period:
Estimated Discharge Date:	
Authorization End Date Extension *(indicate the new end date, only if requesting an extension of the original authorization):*	Number of Days Member Was Absent from Program *(required for CCR):*
Days of Program: ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday ☐Sunday	

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Current Diagnoses *(include ICD-10 code and narrative/title):*
Changes in Symptoms Since Admission *(include current symptoms, impairments, stressors):*
Risk Level:
Suicidal Ideation/Attempt/Self-Injurious Behaviors:
Homicidal Ideation/Attempt:
Psychosis/Delusions/Command Auditory Hallucinations:
Involuntary Treatment:
Member Requires Seclusion/Restraints *(if yes, please explain):*
Safety Checks/Frequency:
Treatment History:
Current Medications *(include medication-assisted treatment, recent changes, compliance, and frequency of MD evaluation):*
Co-morbid Conditions Impacting Mental Status *(include vitals, chronic/acute medical issues, labs, UDS, EKG, malnutrition, physical side effects, etc.):*

Functional Impairments *(social/occupational/school, etc.):*
Treatment Plan/Goals *(include specific target behaviors, specific and measurable interventions, and progress):*
Clinical Assessments Completed: ☐ Yes ☐No *If No, why not?*
Support System *(include information about family involvement, family sessions and support on discharge):*
Will the member's condition improve in this level of care? *(What symptoms cannot be managed outside this level of care? What is the member's level of motivation to recover?)*
Discharge Plan *(indicate step down level of care, name of outpatient and/or primary care provider, coordination with outpatient providers and living situation at discharge):*

Eating Disorder Only:

Height:	Current Weight:
Body Mass Index:	% Ideal Body Weight:
Sitting Blood Pressure:	Sitting Heart Rate:

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Eating Disorder Only, continued

Abnormal Labs/Tests:
Eating Disorder Behaviors:

Substance Use Disorder Only:

Substance:	Type/Method of Use:
Date of First Use:	Date of Last Use:
Amount Currently Using/Frequency:	
Relapse Risk:	
Withdrawal Symptoms:	
CIWA* *(include date):*	COWS** *(include date):*
12 Step:	Sponsor:

** Clinical Institute Withdrawal Assessment*
*** Clinical Opiate Withdrawal Scale*

For Single Case Agreement Requests: Authorization is contingent on the return of a signed contract, including agreed upon rates AND on medical necessity criteria being met. Final determination of payment is based on the member's benefits, appropriateness of the service provided, and eligibility at the time the service is rendered and the claim is received.

I certify that all information included on this form is true, accurate, and complete.

X _____

Provider Signature Date

----------DO NOT WRITE BELOW THIS LINE----------

Verified member eligibility date:

Verified provider network status:

Plan Type: ☐ HMO ☐ PPO ☐ POS ☐ ASO/Shared Advantage

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