

Magellan PCP Referral Form: Psychosocial Rehabilitation (PSR)

For providers serving Florida members only

Magellan provider/agency information and instructions

Magellan provider/agency, you must:

- (1) Complete sections 1, 2, 3 and 4 of the form.
- (2) Submit signed and completed form with supporting documentation to the member's PCP.
- (3) When you receive a copy of this form signed and dated by the member's PCP as confirmation of PCP referral, submit the completed and signed PCP Referral Form to Magellan via fax at 1-888-656-4151 and store the PCP Referral form along with the supporting documentation in the member's record.
- (4) The PCP Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new PCP Referral Form prior to the referral end date.

Section 1 - Magellan provider/agency information

Provider/agency name: _____

Address: _____

Phone number: _____

Fax number: _____

TIN: _____

NPI: _____

Name of person completing form: _____

Contact information: _____

Start and end date of requested sessions: _____ to _____

Place of service: _____

Section 2 - Member information

Member name:	Member ID:
Address:	Member date of birth:
City/State/ZIP code:	
Member's insurance carrier: CarePlus	
DSM-V diagnosis code(s):	

Section 3 – Supporting documentation for PCP to review with referral request

- **Recent Assessment from the behavioral health provider (e.g., psychiatrist) who is treating the member completed within past 6 months, to include:**
 - All current medical and behavioral health diagnoses
 - Risk of harm status
 - Functional status (Describe current symptoms and behaviors and the impact they have on current functioning.)
 - Member's current and potential strengths
 - Describe current support system available
 - Environmental stressors
 - Mental health/substance abuse treatment history
 - Describe member's self-determination/motivation to participate in treatment
 - List of current medications
- **Copy of Initial Treatment Plan (for those just starting care); Treatment Plan (for those already in care), to include:**
 - Measurable treatment goals with expected target dates of completion
 - Member goals that have been met during the initial period
 - Member's progress toward achieving unmet targeted goals
 - All identified barriers to member's progress in meeting targeted goals
 - Other information that will support the medical necessity for continued PSR services being requested
- **Clinical Notes including:**
 - Copies of daily progress notes for PSR services

Section 4 – Magellan provider/agency attestation

I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name

Signature

Date

Section 5 – Primary care physician (PCP)

THIS SECTION TO BE COMPLETED BY THE PCP ONLY

PCP information and instructions

PCP, you must:

- (1) Verify that sections 1, 2 and 4 of this form are complete.
- (2) Fill in this section 5 of the form, sign, and date.
- (3) Fax the signed, completed form to the requesting provider/agency (refer to contact details under section 1).
- (4) Provide member with a copy of the signed, completed form.

PCP name: _____

PCP address: _____

PCP phone number: _____

PCP fax number: _____

PCP signature: _____

Referral date: _____