

# MAGELLAN PROVIDER INFORMATION FORM

**CHECK THE APPROPRIATE PROVIDER TYPE:**     Individual                       Group\*

\*Please complete one form for the group and then photocopy and complete supplemental versions of this form for each group member. Only complete the **Practitioner Data** sections for each supplemental version.

## Practitioner Data - General Information

Provider First Name:	MI:	Last Name:	Suffix:
Degree (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DPM <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> CNM <input type="checkbox"/> Other: _____			
SSN:	NPI:	DOB:	
CAQH #:	Medicare ONLY provider: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you practice exclusively within the inpatient setting?* (E.g. Pathologists, Anesthesiologists, ER Physicians, Nurse Practitioner, Radiologists, Physician Assistant, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Indicate the locations where the practitioner provides services: <input type="checkbox"/> Primary <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/> #5 <input type="checkbox"/> #6 <input type="checkbox"/> #7 <input type="checkbox"/> #8 <input type="checkbox"/> #9			

## Main Site Practice Information

Primary Service Location Address (include ZIP + 4):	
Hospital Based: <input type="checkbox"/> YES <input type="checkbox"/> NO	Panel Status: <input type="checkbox"/> Accepting New Patients <input type="checkbox"/> Existing Patients Only <input type="checkbox"/> Nursing Home Setting Only
Group Name:	
DBA, if applicable	
Main Site Phone # :	Group NPI:
Office Hours:	Practice Website:

## Mailing Address

Mailing Address (if different from primary practice address):
Admin Phone:
Primary Email:

## Pay To Information

Pay To:	TIN:
Pay To Address:	

## Practitioner Data - Other Languages Spoken (*Please check all that apply*)

<input type="checkbox"/> Spanish	<input type="checkbox"/> German	<input type="checkbox"/> French	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Korean	<input type="checkbox"/> Navajo	<input type="checkbox"/> Tagalog
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Italian	<input type="checkbox"/> Arabic	<input type="checkbox"/> Dakota	<input type="checkbox"/> Polish	<input type="checkbox"/> Other:	

## Provider Designation

**Please select the Provider Designation/Type(s). Please check all that apply.**

Type	Description	Type	Description
<input type="checkbox"/> 01	Primary Care Provider (PCP)	<input type="checkbox"/> 16	Outpatient Rehabilitation ( <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST)
<input type="checkbox"/> 02	Pediatrician	<input type="checkbox"/> 17	Durable Medical Equipment (DME) and Supplies
<input type="checkbox"/> 03	Specialist (list specialty):	<input type="checkbox"/> 18	Radiology
<input type="checkbox"/> 04	Health Department	<input type="checkbox"/> 19	Home Health
<input type="checkbox"/> 05	Hospice	<input type="checkbox"/> 20	Laboratory
<input type="checkbox"/> 06	Long Term Services & Supports (LTSS)	<input type="checkbox"/> 21	Pharmacy
<input type="checkbox"/> 07	Outpatient Mental Health – Traditional Services	<input type="checkbox"/> 22	Vision
<input type="checkbox"/> 08	Addiction, Recovery, & Treatment Services (ARTS)	<input type="checkbox"/> 23	Transportation ( <input type="checkbox"/> Emergency <input type="checkbox"/> Non-Emergency)
<input type="checkbox"/> 09	Community MH Rehabilitative Services (CMHRS)	<input type="checkbox"/> 24	Other (please describe):
<input type="checkbox"/> 10	Hospital - Psychiatric	<input type="checkbox"/> 25	OB/GYN
<input type="checkbox"/> 11	Hospital – General ( <input type="checkbox"/> Pediatric)	<input type="checkbox"/> 26	Federally Qualified Health Center (FQHC)
<input type="checkbox"/> 12	Hospital – Physical Rehabilitation	<input type="checkbox"/> 27	Community Services Board (CSB)
<input type="checkbox"/> 13	Urgent Care	<input type="checkbox"/> 28	Rural Health Clinic (RHC)
<input type="checkbox"/> 14	Nursing Facility ( <input type="checkbox"/> Intermediate <input type="checkbox"/> Skilled)	<input type="checkbox"/> EI	Early Intervention

Email [MCCVAProvider@MagellanHealth.com](mailto:MCCVAProvider@MagellanHealth.com) or fax to 888-656-5098

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## Long-Term Services & Supports (LTSS) Procedure Codes

Please select the service codes you provide. **Please check all that apply.**

Proc Code	Description	Proc Code	Description	Proc Code	Description
<input type="checkbox"/> S5102	Adult Day Health Care	<input type="checkbox"/> S5160	PERS Installation	<input type="checkbox"/> H2000	Service Fac Initial Comprehensive Visit
<input type="checkbox"/> T1999	Assistive Technology Only	<input type="checkbox"/> S5185	PERS Medication Monitoring	<input type="checkbox"/> S5116	Service Fac Management Training Hrs
<input type="checkbox"/> T1000	Congregate Nursing/RN	<input type="checkbox"/> S5161	PERS Monitoring	<input type="checkbox"/> T1028	Service Fac Reassessment Visit
<input type="checkbox"/> T1001	Congregate Nursing/LPN	<input type="checkbox"/> H2021	PERS Nursing Svcs/LPN or RN	<input type="checkbox"/> 99509	Service Fac Routine Visit
<input type="checkbox"/> T1030	Congregate Respite Nursing/RN	<input type="checkbox"/> T1019	Personal Care	<input type="checkbox"/> T1003	Skilled Nursing Services/LPN
<input type="checkbox"/> T1031	Congregate Respite Nursing/LPN	<input type="checkbox"/> T1005	Respite Care	<input type="checkbox"/> T1002	Skilled Nursing Services/RN
<input type="checkbox"/> 99199	Environmental Mod, Maint Costs Only	<input type="checkbox"/> S9125	Respite Care LPN	<input type="checkbox"/> H2015	Transition Coordination
<input type="checkbox"/> S5165	Environmental Modifications Only	<input type="checkbox"/> S5109	Service Facilitation Training Visit		

## Substance Use Disorder (SUD) Procedure Codes

Please select the service codes you provide. **Please check all that apply.**

Procedure Code	Description	Procedure Code	Description
<input type="checkbox"/> H0011, Rev 1002	Inpatient Acute	<input type="checkbox"/> H0006	SUD Case Management
<input type="checkbox"/> H0010, H2034, H2036, Rev 1002	Residential Services	<input type="checkbox"/> H0007	SUD Crisis Intervention
<input type="checkbox"/> H0035, Rev 0913	Partial Hospitalization	<input type="checkbox"/> H0038, T1012, S9445, S9446	SUD Peer Recovery Supports
<input type="checkbox"/> H0015	Intensive Outpatient (IOP)	<input type="checkbox"/> CPT Codes	Outpatient SUD – Individ, Family & Grp Svcs
<input type="checkbox"/> H0014, H0020, G9012, CPTs 99205 & 99215	Medication Assisted Treatment (MAT) - Suboxone or Methadone Clinic Suboxone Office-Based Treatment	<input type="checkbox"/> Q3014	SUD Telehealth

## Non-Traditional Mental Health Services Procedure Codes

Please select the service codes you provide. **Please check all that apply.**

Procedure Code	Description	Procedure Code	Description
<input type="checkbox"/> H2023	Mental Health Case Management	<input type="checkbox"/> H0035 HB	Day Treatment/ Partial Hospitalization for Adults
<input type="checkbox"/> H0024	Peer Support Services, Individual Mental Health	<input type="checkbox"/> H0036	Crisis Intervention
<input type="checkbox"/> H0025	Peer Support Services, Group Mental Health	<input type="checkbox"/> H0039	Intensive Community Treatment
<input type="checkbox"/> H0031	IIH Assessment	<input type="checkbox"/> H0046	Mental Health Skill-building Services (MHSS)
<input type="checkbox"/> H0032 U6	Psychosocial Rehab Assessment	<input type="checkbox"/> H2012	Intensive In-Home
<input type="checkbox"/> H0032 U7	Therapeutic Day Treatment (TDT) Assessment, Child	<input type="checkbox"/> H2017	Psychosocial Rehab
<input type="checkbox"/> H0032 U7	Day Treatment/Partial Hospitalization Assessment Adult	<input type="checkbox"/> H2019	Crisis Stabilization
<input type="checkbox"/> H0032 U8	MHSS Assessment	<input type="checkbox"/> H2033	Multisystemic Therapy (ABA)
<input type="checkbox"/> H0032 U9	ICT Assessment	<input type="checkbox"/> H0038, T1012	Peer Support Services- Individual
<input type="checkbox"/> H0032 UA	Behavioral Therapy Assessment	<input type="checkbox"/> S9445, S9446	Peer Support Services- Group
<input type="checkbox"/> H0035 HA	Therapeutic Day Treatment (TDT) for Children	<input type="checkbox"/> T1016	Treatment Foster Care Case Management
<input type="checkbox"/> H0035 HA & U7	TDT Summer Program for Children	<input type="checkbox"/> H2022	Level A Group Home
<input type="checkbox"/> H0035 HA & UG	TDT Afterschool Program for Children	<input type="checkbox"/> H2020	Level B Group Home

## Other Practice Locations

<b>#2</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#3</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

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## Other Practice Locations

<b>#4</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#5</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#6</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#7</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#8</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

<b>#9</b>	Organization / Facility/ Group / Practice Name:		
	Service Location Address (include ZIP+4):		
	Phone#:	Fax:	Accepting New Patients: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Have 24 hour Access: <input type="checkbox"/> YES <input type="checkbox"/> NO		Office Hours:
	Office Contact Name:		Office Contact Email:

***Please use additional sheets as needed for additional locations.***

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