Magellan COMPLETE CARE

Magellan Behavioral Health Psychiatric Inpatient Concurrent Authorization Form

Member information		
Member name:		Member ID/Policy #
Member DOB:		Date of admission:
TDO/ECO: ☐ Yes ☐ No	Hearing date:	Hearing outcome:

Facility information	
Facility name:	Facility NPI:
Attending MD:	Attending MD NPI:
Is the facility in the MCC of VA network? ☐ Yes ☐ No	If yes, please provide NPI:
Tax ID:	Provider UM contact:
UM phone:	UM fax:
Discharge planner's name:	Discharge planner's phone:

Psychiatric/substance use diagnosis with ICD-10 codes:			

Pertinent medical information
Changes in diagnosis:
Patient's medical history and/or current medical issues or concerns:
Pertinent lab value(s) with dates:
Pertinent vital signs and CIWA/COWS scores with dates:

Please submit all relevant clinical information through the Availity portal or fax to the number below:
CCC Plus and Medallion 4.0: 1-855-339-8179 MCC of VA (HMO SNP): 1-888-656-2621

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Current clinical presentation (for dates of service requiring review):		
Review date (first uncovered day):		
Suicidal: ☐ Denies ☐ Reports ☐ Plan Details:		
Homicidal: ☐ Denies ☐ Reports ☐ Plan Details:		
Duty to warn reported: ☐ Yes ☐ No If no, please explain:		
Self-Harm: ☐ Denies ☐ Gesture(s) Details:		
Aggression: ☐ Denies ☐ Behaviors Details:		
Psychosis symptoms: ☐ Delusions ☐ Paranoia Hallucinations: ☐ Denies ☐ Visual ☐ Auditory ☐ Tactile Details:		
Precautions: ☐ Suicide ☐ Elopement ☐ 1:1 ☐ Line of Sight	Date precautions initiated:	Date precautions discontinued:
Seclusion/restraints since last review:		
PRN medications received:		

Physician notes
Physician clinical summary since last review (please include original copies of physician/provider notes):
Mental status exam:
Risk assessment:
Medication changes:

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Other notes
Group therapy notes (if applicable):
Family therapy notes (if applicable):
Nursing/staff notes since last review:
Discharge planning
Discharge disposition:
Scheduled appointments:
Scheduled transfers or phone interviews:
Additional information
Any critical incidents (please explain):
Please include any other pertinent information to support the behavioral health psychiatric inpatient stay:

Form filled out by:	Date:

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