Provider/Magellan Logo

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at 1-800-564-5465 and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at 1-800-564-5465. This notice is available in other languages and formats if you need it.

Si usted tiene problemas leyendo éste aviso debido a que las letras son muy pequeñas o las palabras son muy difíciles de leer, por favor llame a nuestra oficina al 800-564-5465 y alguna persona le ayudará. Si éste aviso no le proporciona la información que usted busca o la decisión que tomamos y el por qué, por favor llámenos al número 800-564-5465. Esta comunicación está disponible en otros idiomas y formatos si usted lo necesita.

PM FORM 5.1.2

(Click here for Spanish Version)

NOTICE OF EXTENSION

TO: **[ENROLLEE'S/LEGAL REPRESENTATIVE'S NAME/ADDRESS]**

FROM: **(Name/Address of agency)**
CONTACT PERSON/NUMBER

DATE:

(Your doctor OR name of provider –*as appropriate*) has asked that Magellan Health Services pay for (*describe services requested and the reason for the services in easily understood language). You or the name of the requesting provider -- if the member or requesting provider has requested the extension or Magellan Health Services)* feels that it is in your best interest to take up to fourteen (14) more days to make a decision. We need this time so we can get more information from (*insert name of requesting provider).* We need *(insert what additional information is needed, e.g. notes from your doctor that tell us if you have tried Drug X before, or notes from your doctor that tell us if you have had a chest x-ray. Be as specific as possible in what information is needed in order to assist the member in getting the service or provides the member with an idea of what information is missing that the member may be able to supply).*

We will make this decision by *(insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date of the letter which represents the mail date.) If we do not get the information from (insert name of requesting provider) then we will have to deny this request.*

If you do not agree with us taking extra time to make a decision you can file a complaint. You can do this by contacting Magellan Health Services at 1-800-564-5465 or you can send a written complaint to:

Provider/Magellan Logo

Magellan Health Services of Arizona
ATTN: Complaints Resolution
4801 E. Washington, Suite 100
Phoenix, Arizona 85034

If you need help with making a complaint, you may contact the State Protection and Advocacy System, the Arizona Center for Disability Law, at 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. Persons with a serious mental illness (SMI) may contact an Advocate at the Office of Human Rights at 1-602-364-4574 or 1-800-421-2124. For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Magellan Health Services can decide to take extra time if we feel it will be of help to you. We felt extra time would help us get the information needed to make a decision.

Sincerely,

Magellan Health Services