MAGELLAN BEHAVIORAL HEALTH

Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Behavioral Health Inpatient Facility or Behavioral Health Residential Facility

Form 3.14.10

(FAX completed form to: Magellan Childrens' Care Management at 1 866-568-6147)
Failure to submit update within 4 days will result in denial of Prior Authorization

Reciepent Information	
C/A Name:	Case Manager:
Fax:	PNO/QSP:
Date this C/A was previously approved for Residential Treatment:	Level of care previously approve:

The following information is needed to confirm that this Level of Care is still medically necessary because this C/A has not been admitted within 45 days from the date of approval. Please submit this information **via Fax** to the Magellan within 72 hours for an updated review. You will be notified by **Fax Response form** of this C/A's Level of Care Determination.
PLEASE INCLUDE current **psychiatric progress note and any service provider notes.**

Current Psychiatric Symptoms/Behaviors
Date of Last Psychiatric Visit:
Specify an y current Substance Abuse and Treatment that is now being utilized:
Current Mental Status:
Services/Natural Supports currently in place to maintain the C/A in the community (Please include frequency, duration, and outcome of services):
Why does the C/A still require this Level of Care? (Describe behaviors /symptoms that continue to fail community based services)