# OUTPATIENT SINGLE CASE AGREEMENT REQUEST FORM

## FAX or Email to LaMona Kelly:
## 1-866-892-5023 or LKelley@magellanhealth.com

| A. INDICATE NEW OR RENEWAL REQUEST BELOW: | |
|---|---|
| ☐ New Request | ☐ Renewal * |
| * If this a renewal of service indicate the origination date of service: | |

| B. MEMBER INFORMATION: | |
|---|---|
| 1. Member name: | 2. DOB: |
| 3. CIS, 10 digit numeric, or alpha-numeric ID number: | 4. Benefit: |

| C. REQUESTING PERSON/SITE/AGENCY INFORMATION: | |
|---|---|
| 1. Clinician's or Clinical Coordinator's name: | 2. Behavioral Health Medical Practitioner's name: |
| 3. Site or location: | 4. Phone: |
| 5. Fax number: | 6. Approving Clinical Director or Medical Director's name, phone number: |

| D. PROVIDER INFORMATION (please obtain directly from the provider): | |
|---|---|
| 1. Provider name: | 2. Provider service location/telephone/fax numbers: |
| 3. Provider billing address/telephone/fax numbers: | 4. Provider email address: |
| 5. Required provider ID numbers:<br>a. AHCCCS ID number:<br>b. Tax ID number:<br>c. NPI number: | 6. Covered service CPT or HCPC code: |

| d. MIS number: | a. POS-Place of Service and units: |
|---|---|
| 7. Length of sessions: | 8. Frequency of contact: |
| 9. Dates of service including initial appt date: | |

| **E. DIAGNOSTIC & CLINICAL INFORMATION (please list number and name):** |
|---|
| 1. Axis I: |
| 2. Axis II: |
| 3. Axis III: |
| 4. Axis IV: |
| 5. Axis V: |
| 6. Describe concrete achievable goal(s): |
| 7. Describe types of intervention(s) utilized to achieve goal(s): |

| | **Outpatient Single Case Agreement Requests** |
|---|---|

|  |
|---|
| 8. ELOS: |
| 9. Reason for requesting the SCA and any in-network providers that were considered: |

## F. FOR RENEWALS ONLY:

|  |
|---|
| 1. Describe treatment progress: |
| 2. Explanation or reason goals were not achieved: |
| 3. Revised or modified goals: |
| 4. Revised or modified interventions: |
| 5. Revised or modified ELOS: |

## G. LIST PROVIDERS CONTACTED FOR THIS REFERRAL:

| Provider | Date referred | Date responded | Reason |
|---|---|---|---|
|  |  |  |  |
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|  |  |  |  |

## H. SMI Outpatient Clinical Team Approval:

_______________________________________ Clinical Director

_______________________ Date

______________________________ ______________________

Regional Clinical Director Date

## I. GHMHSA Outpatient Clinical Team Approval:

______________________________ ______________________

Clinical Director or Medical Director Date

## J. FOR MAGELLAN RBHA INTERNAL USE ONLY:

☐ Additional information is needed to process this request as follows:

☐ Application complete & ready for Medical Director clinical review.

______________________________ ______________________

Care Manager Date

☐ Additional clinical information is requested by the Medical Director as follows:

☐ Application is complete, clinical information reviewed and approved:

______________________________ ______________________

Medical Director Date