TREATMENT REQUEST FORM
(TRF)

Cover sheet not required

Magellan Behavioral Health
and affiliated entities including Magellan Behavioral Health Systems, LLC f/k/a Human Affairs International, Inc., Green Spring Health Services, Inc., CMG Health Inc., Merit Behavioral Care Systems Corporation, and Magellan Health Services of California, Inc-Employer Services.

Fax: 1-800-501-0185

PATIENT INFORMATION

PATIENT'S NAME

DATE OF BIRTH MEMBERSHIP NUMBER

AUTHORIZATION NUMBER

PRACTITIONER INFORMATION

PRACTITIONER ID# PHONE NUMBER

PRACTITIONER NAME & ADDRESS

REQUESTED SERVICES

¤Required Information

***Requested Start Date for this TRF (MM/DD/YYYY)** ☐☐/☐☐/☐☐☐☐

***Primary Diagnosis** ☐☐☐.☐☐

Secondary Diagnosis ☐☐☐.☐☐

*CPT CODE: Select Frequency associated with Code(s) Requested: Weekly, Every other Week, Monthly, Quarterly or Other.

	Wkly	EoW	Mon	Qtrly	Oth
90804	O	O	O	O	O
90807	O	O	O	O	O
90847	O	O	O	O	O

	Wkly	EoW	Mon	Qtrly	Oth
90805	O	O	O	O	O
90808	O	O	O	O	O
90853	O	O	O	O	O

	Wkly	EoW	Mon	Qtrly	Oth
90806	O	O	O	O	O
90809	O	O	O	O	O
90862	O	O	O	O	O

Note: Information supplied by some providers may be limited by applicable state law. In those cases, please complete all sections that you believe you are permitted to answer pursuant to the applicable state law.

This patient requires additional sessions because the patient is/has (check the one that is the most prevalent):

O resistant to treatment
O ongoing medication management
O additional sessions need to support termination of therapy
O maintenance treatment required to maintain optimal symptom relief
O significant life event complicating treatment
O not at baseline functioning
O other (explain below briefly) _____

Is this patient on a medication prescribed by you or another practitioner to treat this condition? O Yes O No

Important note: Requests for multiple procedures does not result in an increase in total number of visits approved. After review of this request, an authorization letter will be mailed to you describing the number of sessions approved, date span of the sessions, and how to request additional sessions.

ADDITIONAL PATIENT INFORMATION

Does the patient have a chronic medical condition (e.g. Diabetes, Asthma, CHF, CAD, Chronic Pain, other)? O Yes O No

I have communicated with the PCP or other relevant health care provider about treatment? O Yes O No O Patient Refused Permission

Currently on Disability for MH/SA? O Yes O No

Clinical outcomes measured: O SF - BH/CHI/CHI-C O Other (explain) _____ O None

_____ *Date ☐☐/☐☐/☐☐☐☐

*Print name of treating provider

Only treating providers or their office personnel may submit this form. By submission of this TRF, I attest that the treating provider has a current valid license in the state to provide the requested services, and has collected all appropriate copays and coinsurance.

Submit your request online to www.MagellanHealth.com/provider for real-time response. Also on this site you can check member eligibility, check authorization and claim status, view outcomes reports, access clinical guidelines, earn CEUs and much more.

TRF Version 7.0

Magellan Health Services
Treatment Request Form (TRF) Instructions

What is a TRF and How is it Used?

- The Magellan Treatment Request Form (TRF) is used to request additional outpatient treatment sessions for a specific member. **Only treating providers or their office personnel may submit this form.**
- A TRF must be submitted **two (2) weeks prior** to the expiration of the current authorization to avoid possible disruption in claims payment.
- In most cases, the member and provider information is already entered on the form; therefore **the TRF can only be used for the member for whom it has been prepared.**
- For a real-time response to your authorization request, we invite you to login to www.MagellanHealth.com/provider and submit your TRF online.

Instructions for Completing the TRF

- Use a **black pen** to complete the form.
- Fill circles completely. Example: ● **Do not use** ✓ **or** -- **or** /
- Use whiteout to correct errors.
- Please answer **all** questions including the following:
    - **Requested Start Date for this TRF**—Enter the date on which you would like this new authorization to begin.
    - **Diagnosis Codes**—Enter a primary DSM-IV TR diagnosis code. A secondary diagnosis may be entered, if applicable.
    - **CPT Codes**— Fill in **one** Frequency circle next to the CPT Code(s) you are requesting for this authorization.
    - **Reason for additional sessions**—Select only **one** option by filling in the circle(s) in front of the option that is most prevalent. Provide a brief description in space available if "Other" is selected.
    - **Clinical Outcomes Measured**—Please select the option to describe how clinical outcomes are being measured. List the specific clinical tool used if "Other" is selected.
- Print the name of the treating provider and enter the date the form is completed.
- Fax the completed TRF ***to the fax number on the form.***

To Avoid Delays in Processing Your TRF

- Do not add narrative information other than in the two fields described in the instructions above.
- Do not alter a form to use for another member.
- Do not leave any fields blank. Incomplete forms will be returned *without* authorization.
- Do not send a cover sheet when faxing.

The Magellan TRF cannot be used to request ongoing outpatient care for the following states, accounts, or services:

• Maryland •ChampVA •Magellan employees and their dependents

•Most carve-out Medicaid accounts •Levels of care other than routine outpatient