

District of Columbia

Release of Mental Health Information for Outpatient Mental Health Treatment

This form is designed to authorize the disclosure of the mental health information listed below by the individual practitioner to determine entitlement and payment of claims for reimbursement. It is not to be used for in-patient or partial hospitalization.

Carrier or Appropriate Recipient:
Magellan Behavioral Health
Fax: 800-365-5030
- or -
PO Box 4930
Columbia, Maryland 21046-4930

CLIENT INFORMATION / PRACTITIONER INFORMATION
CLIENT'S FIRST NAME, CLIENT'S DATE OF BIRTH, PRACTITIONER ID# or TAX ID, PHONE NUMBER
MEMBERSHIP NUMBER, AUTHORIZATION NUMBER (If Applicable)
PRACTITIONER NAME, LICENSE#, ADDRESS & PHONE (Fax optional)
Date Client First Seen For This Episode Of Treatment
Status? Voluntary / Involuntary
MULTIAXIAL DIAGNOSIS CODE\* (PLEASE COMPLETE ALL FIVE AXES)
\*DSM, ICD or Other Recognized Code
AXIS I, II, III, IV, V: GAF Score
Current Medications and prescribing practitioner (if applicable):
Reason for Continuing Treatment and Treatment Goals:
Prognosis (limited to estimated duration of treatment):
Authorization Request Details
Modality of treatment maybe conveyed via CPT code or by describing in the field provided below.
(CPT Code, Modality, Frequency, Requested Start Date of Authorization)
Client's Consent: By signing below, I agree to share this information with the designated 3rd party payer (administrator).
Signature of Client, Signature of practitioner\*
\*My signature attests that I have consent from the Client to release this information.