Addictive and Mental Disorder
Division Data Corrections Request
All forms must be typed. Handwritten or incomplete forms will be returned

Date of Request: _____

Request Type: ☐ Mental Health ☐ Substance Use Disorder

Provider Information

Contact Name: _____ Provider ID: _____

Phone Number: _____ Ext: _____ Fax: _____

Description of the Problem

Facility's Justification (Mandatory)

Member Information

Member Name: _____ Birthdate: _____ Social Security: _____

Medicaid Number: _____ Admission Date: _____ Discharge Date: _____

Prior Authorization Number: _____ Request ID Number: _____

Authorized Signature: _____ Date: _____

Fax Completed Form To

Magellan Medicaid Administration

Fax: 800-639-8982 Phone: 866-545-9428

Magellan Medicaid Administration's Use Only

Nurse or CCS Assigned: _____ Date Correction Determination: _____

Reviewer's Signature: _____ Date: _____

Print Form Save Form Reset Form