Facsimile Request for
Criteria For Medical Necessity Determination

To: _____ From: _____

Mgd Care Co: _____ Provider: _____

Fax: _____ Fax: _____

Phone: _____ Phone: _____

Please disclose and/or make available the criteria used for your medical necessity determination, (as required by the 2008 Mental Health Parity & Addiction Equity Act), regarding:

Patient/Insured's Name: _____

Insurance Company: _____

Insurance Policy ID#: _____

Level(s) of care requested: _____

IF THERE HAS BEEN A DENIAL OF AUTHORIZATION FOR TREATMENT, PLEASE PROVIDE THE SPECIFIC REASONS FOR DENIAL.

Should you have any questions regarding this request, please contact me at the phone number listed above.