Magellan Behavioral Health of Pennsylvania, Inc.
Provider Access Form

☑ Bucks County  ☑ Cambria County  ☐ Delaware County  ☐ Lehigh County  ☐ Montgomery County  ☐ Northampton County

This form is to be used when a decrease in provider capacity will compromise the provider’s ability to meet time/access standards. This form must be faxed within 24 hours (1 business day) to Magellan Behavioral Health of Pennsylvania, Inc. at 1-866-667-7744. Issues can also be reported online at www.magellanprovider.com.

Provider Name (Specify Site): ____________________________
Provider Phone #: ____________________________
Provider Fax #: ____________________________

Level(s) of Care or Specific Program Being Affected:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Detail the Specific Problem Causing Decreased Service Capacity:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Provider Proposed Corrective Action Addressing the Decreased Service Capacity:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Projected Timeframe That Decreased Capacity Will Last:
________________________________________________________________________
________________________________________________________________________

Provider Signature ____________________________ Date ____________________________

MAGELLAN USE ONLY - Internal Tracking: Responsible party should initial and date each section.

Magellan Notified of Provider Issue: ____________________________________________
Access Form Sent to Provider: ____________________________________________
Access Form Received at Magellan from Provider: ____________________________
Access Form Sent by Magellan to County-OBH (If Referral Capacity is Affected): ____________________________
Access Form Sent by County OBH to DHS (If Referral Capacity is Affected): ____________________________