



Molina Healthcare of Florida (MHF) In-Network Specialist Referral Form

Fax (MMA/LTC/Specialty): 866-440-9791 Fax (MCR/Inpatient): 844-834-2152 Fax (MCR/Prior Authorizations): 844-251-1450 Fax (MP): 833-322-1061

Date:	
Patient Name:	
DOB:	
Member ID:	

THIS REFERRAL IS VALID FOR 90 DAYS OR UP TO 6 MONTHS ONLY.

(A referral is not required for visits to providers with the following specialties – Obstetrics and Gynecology, Dermatology, Chiropractic and Podiatry)

1. Provide original form to Member to be presented to specialist.
2. Forward a copy to requested specialist.
3. Place a copy in Member’s medical record.
4. Include all necessary clinical information with this referral.

Diagnosis Description:	ICD 10 Diagnosis Code:
Referred To:* _____ <small>*Must refer to a specialist within network</small> Specialty: _____ Address: _____ _____	Specialist Phone Number: _____ Specialist Fax Number: _____ Check one: <input type="checkbox"/> Standard Referral (up to 3 visits for 90 days) <input type="checkbox"/> Standing Referral. Enter the number of visits _____. Standing referrals are valid for up to 6 months.

Clinical Reasons for Referral:

Requesting PCP:	
Phone Number:	
Fax Number:	
Signature:	
Date:	

Please complete this form and fax to the numbers above or visit: Provider.Molinahealthcare.com/provider/login to submit via the Provider Web Portal.