

Molina® Healthcare, Inc. – Prior Authorization Request Form

Providers may utilize [Molina's Provider Portal](#):

- Claims Submission and Status
- Authorization Submission and Status
- Member Eligibility

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Duals	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):			
Member Name:			DOB (MM/DD/YYYY)
Member ID#:			Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Other (Please Specify): _____ <input type="checkbox"/> Inpatient ER Admission (Concurrent) <input type="checkbox"/> EPSDT/Special Services		<input type="checkbox"/> Time Sensitive (Rationale): _____

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/Renewal/Amendment	<input type="checkbox"/> Previous Auth #
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing (SNF) <input type="checkbox"/> Other Inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: _____ Description: _____

DATES OF SERVICE		PROCEDURE/SERVICES CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
Start	Stop				

PROVIDER INFORMATION

Requesting/Referring Provider/Facility:

Provider Name:	NPI#:	TIN#:
Phone:	Fax:	Email:
Address:	City:	State:
PCP Name:	PCP Phone:	Zip:
Office Contact Name:	Office Contact Phone:	

Servicing/Billing Provider/Facility:

Provider/Facility Name (Required):				
NPI#	TIN#	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par	<input type="checkbox"/> COC
Phone:	Fax:	Email:		
Address:	City:	State:	Zip:	

For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.