

Molina® Healthcare, Inc. – Prior authorization service request form

Member information				
Line of business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<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"/> Urgent/expedited—clinical reason for urgency (required): _____ <input type="checkbox"/> Emergent inpatient admission <input type="checkbox"/> EPSDT/special services			

Referral/service type requested			
Request type:	<input type="checkbox"/> Initial request	<input type="checkbox"/> Extension/renewal/amendment	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 Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other inpatient: _____	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic/genomic 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/ service codes	Diagnosis code	Requested service	Requested Units/visits
Start	Stop				

Provider information					
Requesting provider/facility:					
Provider name:		NPI #:		TIN #:	
Phone:		Fax:		Email:	
Address:		City:		State:	Zip:
PCP name:		PCP phone:			
Office contact name:		Office contact phone:			
Servicing 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:					

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.