Molina® Healthcare, Inc. – Prior Authorization Request Form

Marketplace Fax: (833) 322-1061 Phone: (855) 237-6178

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., CA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone:**	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required:** _____ ☐ Emergent Inpatient Admission ☐ EPSDT/Special Services			

REFERRAL / SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient: _____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

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):**	☐ **Non-Par**	☐ **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.

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Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency **Required:** _____ ☐ Emergent Inpatient Admission			

REFERRAL / SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐ Involuntary ☐ Voluntary ☐ Inpatient Detoxification ☐ Involuntary ☐ Voluntary If Involuntary, Court Date: _____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: **Description:**

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

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):**	☐ **Non-Par** ☐ **COC**	
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	
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