Molina Healthcare – Prior Authorization Service Request Form

EFFECTIVE 08/01/2021 **PHONE** (855) 237-6178

FAX TO: Medicaid (866) 423-3889; Pharmacy (855) 571-3011; MMP - Duals (844) 251-1451; DSNP - Complete Care (844) 251-1459

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/Genomic 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: _________

J Code Drug Requests (Include J Code, Drug Name, Dosage, and Frequency)

J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	

Please send clinical notes and any supporting documentation

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

Dates of Service Start	Dates of Service 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:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.