Molina Healthcare of South Carolina

Important Information. Please Read.

NEW FAX FOR PHYSICIAN ADMINISTERED MEDICATION REQUESTS

Dear Provider:

Effective August 1, 2021, Molina Healthcare of South Carolina will require all Medicaid and Marketplace physician administered prior authorization medication requests to be faxed to our Pharmacy team at the following number: **(855) 571-3011**.

The grid below includes Molina's current prior authorization fax numbers for each line of business:

	Medicaid	Marketplace	Dual Options Medicare-Medicaid (MMP)	Medicare Complete Care HMO (DSNP)
Outpatient & Elective Inpatient	(866) 423-3889	(833) 322-1061	(844) 251-1451	(844) 251-1450
Advanced Imaging	(877) 731-7218	(877) 731-7218	(877) 731-7218	(877) 731-7218
Inpatient Admission Notification & Concurrent Review	(866) 423-3889	(833) 322-1061	(844) 834-2152	(844) 834-2152
Transplant Requests	(866) 423-3889	(877) 813-1206	(877) 813-1206	(877) 813-1206
Pharmacy Requests	(855) 571-3011	(855) 571-3011	(866) 290-1309	(866) 290-1309

An updated **Prior Authorization Request Form** is attached for your convenience and can be found on our website at molinahealthcare.com/providers/sc/medicaid/home. The form is located on the right column.

For questions, please contact Molina Provider Services, Monday - Friday 8 a.m. to 5 p.m., at (855) 237-6178 and press 2 to speak with the Pharmacy department.

CONFIDENTIALITY NOTICE: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify Molina Healthcare of South Carolina immediately via telephone at 855-882-3901 Attention: Compliance Department.

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:
- ☐ Inpatient Hospital
- ☐ Inpatient Transplant
- ☐ Inpatient Hospice
- ☐ Long Term Acute Care (LTAC)
- ☐ Acute Inpatient Rehabilitation (AIR)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Other Inpatient:__________

Outpatient Services:
- ☐ Chiropractic
- ☐ Dialysis
- ☐ DME
- ☐ Genetic/Genomic Testing
- ☐ Home Health
- ☐ Hospice
- ☐ Hyperbaric Therapy
- ☐ Imaging/Special Tests
- ☐ Office Procedures
- ☐ Infusion Therapy
- ☐ Laboratory Services
- ☐ LTSS Services
- ☐ Occupational Therapy
- ☐ Outpatient Surgical/Procedures
- ☐ Pain Management
- ☐ Palliative Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Radiation Therapy
- ☐ Speech Therapy
- ☐ Transplant/Gene Therapy
- ☐ Transportation
- ☐ Wound 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		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):**	☐**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.