MOLINA HEALTHCARE

Molina Healthcare of Washington
IPR/SNF/LTAC Request Form
Phone Number: (800) 869-7175
Fax Number: (800) 767-7188

Attn: _____

MEMBER INFORMATION			
Plan:	☐ **Molina Medicaid**		
Member Name:		**DOB:**	
Member ID#:		**Phone:**	
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	
Request Type	☐ Initial Request for Admit	☐ Continued Stay Review	

***Definition of Expedited/Urgent:** This request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as Elective/Routine.

REFERRAL/SERVICE TYPE REQUESTED	
☐ Inpatient Rehabilitation ☐ Skilled Nursing Facility ☐ Long Term Acute Care	**In order to process requests in a timely manner, please include the following:** • Accepting Facility (unable to process requests without facility) • Admissions Notes—History & Physical • Detailed, current notes regarding the services requested: – PT/OT/ST Evaluations and Progress Notes – Ventilator Setting and RT notes – Wound Care Notes (Dimensions, Treatment Orders) – IV Antibiotic Information (Dose, Frequency, Stop Date)
SNF Bariatric Care:	molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wa/Medicaid/forms/SNF-Bariatric-Request-Form.pdf
Diagnosis Code & Description:	
CPT/HCPC Code & Description:	
Date(s) of Service Requested:	From / / To / /

Please send clinical notes and any supporting documentation at the time of the request.

PROVIDER INFORMATION					
Requesting Facility Name:		NPI#:		TIN#:	
Requesting Facility Phone Number:		Fax Number:			
Accepting Facility Name:		NPI#:		TIN#:	
Accepting Facility Phone Number:		Fax Number:			
Contact at Requesting Provider's office					

CONTINUED STAY REVIEW		
Oxygen/Resp Therapy	☐ No ☐ Yes	Describe (e.g. PRN, 3 Liters etc.):
Wound Care	☐ No ☐ Yes	Describe:
IV Management	☐ No ☐ Yes	Describe:
Total Parenteral Nutrition	☐ No ☐ Yes	Describe:
Labs	☐ No ☐ Yes	Describe:
Other		

Current Therapy Needs		How many more days/weeks projecting to meet goals?
Type	**Current**	**Goal**
Toileting		
Dressing		
Bed Mobility		
Supine to Sit		
Sit to Stand		
Transfers		
Gait		
Other		