

## MOLINA® HEALTHCARE MEDICAID

## Molina Healthcare of South Carolina – Pre-Service Request Form

LAST UPDATED: 04/2024 PHONE: (855) 237-6178

FAX TO: Marketplace (833) 322-1061; Medicaid (866) 423-3889; Pharmacy/J-code requests (855) 571-3011; MMP - Duals (8(1/1) 251-1/151: DSNP - Complete Care (8/1/1) 251-1/150

MMP - Duals	(844) 251-14	51; DSNP - C	omplete Care	e (844) 251-1450
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MEMBER INFORMATION													
Line of Business: 🛛 Medic		caid 🗆 Marketplace 🗆				☐ Medicare [			Date of Request:				
State/Health Plan (i.e. C													
Member Name:							DOB (MM/DD/YYYY):						
Member ID#:							Member Phone:						
Service Ty	pe: 🗆 Non-U	□ Non-Urgent/Routine/Elective											
	-	Urgent/Expedited – Clinical Reason for Urgency <b>Required:</b>											
		Emergent Inpatient Admission EPSDT/Special Services											
REFERRAL / SERVICE TYPE REQUESTED													
				Renewal / Amendment Previous Auth#:									
Inpatient Services:	Outpatient Services:												
□ Inpatient Hospital	Chiropractic			□ Office Procedures				Pharmacy					
□ Inpatient Transplant	Dialysis		Infusion Therapy		Physical Therap			ру					
□ Inpatient Hospice				□ Laboratory Services				Radiation Therapy					
□ Long Term Acute Care (LTA)	Genetic Testing			LTSS Services			□ Speech Therapy						
🗖 Acute Inpatient Rehabilitati	Home Health			Occupational Therapy				□ Transplant/Gene Therapy					
□ Skilled Nursing Facility (SNF	□ Hospice			Outpatient Surgical/Procedures			s 🗆	□ Transportation					
Other Inpatient:	Hyperbaric Therapy			□ Pain Management				U Wound Care					
	Imaging/Special Tests			Palliative Care				D Other:					
P	LEASE SEN	D CLINICAL	NOTE	S AND A	NY	SUPPORTING	DOCUM	ENTATIO	N				
Primary ICD-10 Code:		Descriptior	ו:										
DATES OF SERVICE	PROCEDURE					DEOLIEST					REQUESTED		
START STOP SERVICE CODE		S CODE			REQUESTED SERVICE						UNITS/VISITS		
PROVIDER INFORMATION													
Requesting Provider / F	acility:							1					
Provider Name:				NPI#:				TIN#:					
Phone:		FAX:					Email:						
Address:				City:		1		State:		Zip:	<u> </u>		
PCP Name:				PCP Phone:									
Office Contact Name:		Office Contact Phone:											
Servicing Provider / Fac	ility:												
Provider/Facility Name (Requ													
NPI#:	PI#: TIN#:			Medicaid ID# (If Non-Par):		🗆 Non-			lon-P	Par 🗆 COC			
Phone:		FAX:	FAX:		Email:		Email:	· · ·					
Address:				City:			State:	tate: 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.