



200 Oceangate Long Beach, CA 90802
 (800) 526-8196 • Fax: (800) 811 4804

Tracking#: _____
 Please include Tracking number on claim.
 Expiration Date: _____

SERVICE REQUEST FORM

PRODUCT: **MEDI-CAL** **HEALTHY FAMILIES** **AIM** **MEDICARE**

Service is: **NON-URGENT** **URGENT** **ABUSE OF URGENT PA STATUS WILL BE MONITORED.** Urgent request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. MHC reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below. Date: ____/____/____

Member Name (Last, First, Middle Initial) _____ Date of Birth ____/____/____ Mem I.D.(Social Security Number) ____-____-____

Address (No., Street, City, State, Zip) _____ Phone Number: (____) ____-____

Referral/Service Type Requested

<input type="checkbox"/> Specialist Consult/Tx/FU Care	<input type="checkbox"/> Surgical Procedure	Requested LOS: _____
<input type="checkbox"/> Inpatient Admission	<input type="checkbox"/> Inpatient	Facility: _____
<input type="checkbox"/> Major Diagnostic Procedure	<input type="checkbox"/> Outpatient	Date/Time of Service: _____
<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other: _____
<input type="checkbox"/> DME (refer to PA list)	<input type="checkbox"/> Comments: _____	

Requesting Provider Information **Referring To Provider Information**

Requesting provider name (last, first) _____	Referring to provider name (physician, mg/ipa, facility, agency) _____
Address: (No., Street, City, State, Zip) _____	Address: (No., Street, City, State, Zip) _____
Specialty _____	Specialty _____
Phone Number (____) ____-____	Phone Number (____) ____-____
Fax number (____) ____-____	Fax number (____) ____-____

Service Request Information

ICD-9 Code #/Description: _____ Code or Description: _____

Clinical indications for request: (include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results, etc)

Requesting Practitioner Signature: _____ Date: ____/____/____

MOLINA Use Only

Criteria/guidelines met: yes no Authorization Status: approved modified deferred denied

Comments: _____

UM representative signature: _____ Date: ____/____/____ Approved LOS: _____

MEDICAL DIRECTOR REVIEW

<input type="checkbox"/> APPROVED	COMMENTS: _____
<input type="checkbox"/> MODIFIED	
<input type="checkbox"/> DENIED	

MEDICAL DIRECTOR SIGNATURE: _____ Date: ____/____/____

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CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBILITY FOR DATE(S) OF SERVICE