100 W. Big Beaver, Ste 600, Troy, MI 48084
Phone: 1(888) 898-7969, **Fax: 1 (800) 594-7404**

Tracking #:____________________
Please include tracking number on claim.
Expiration Date: ______________

☐ **NOTIFICATION**

SERVICE REQUEST FORM

CARE TYPE: ☐ Routine ☐ Urgent/Emergent (Within 72 hours) | Date:

MEMBER INFORMATION

Member Name (Last, First, MI)	Date of Birth / /	Member I.D.
Address (No., Street, City, State, Zip)		Phone Number: ( ) -

SERVICE REQUESTED

- ☐ Inpatient Admission, Requested LOS: __________
- ☐ Surgical Procedure
- ☐ Diagnostic Procedure/Radiology
- ☐ Other: (Describe) ____________________________
- Date/Time of Service ________________
- ☐ Home Health
- ☐ Hospice
- ☐ DME
- ☐ Prosthetic/Orthotic
- Number of Visits ____________
- ☐ O2 Respiratory Supplies
- ☐ PT, OT, SP

REQUESTING PROVIDER INFORMATION

Requesting Provider Name (Last, First)	Specialty	Phone Number ( ) -
Point of Contact: (Name & Title)		Phone Number ( ) -
Address: (No., Street, City, State, Zip)		Fax Number ( ) -

REFERRED TO PROVIDER INFORMATION

Referred To Provider Name (Physician, MG/IPA, Facility, Agency)	Specialty	Phone Number ( ) -
Address: (No., Street, City, State, Zip – or Group Tax I.D.)		Fax Number ( ) -

SERVICE REQUEST INFORMATION

ICD-9 Code #/Description: (Required)	CPT/HCPC Code #/Description: (Required)

Clinical Information: (include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results, etc.)
☐ (Supporting Documentation Attached)

Requesting Practitioner Signature/Authorized Personnel:	Date: / /

MOLINA HEALTHCARE USE ONLY

CRITERIA/GUIDELINES MET: ☐ YES ☐ NO | **AUTHORIZATION STATUS:** ☐ APPROVED ☐ DENIED

Comments:
☐ (ATTACHED)

UM REPRESENTATIVE SIGNATURE:	DATE	APPROVED LOS

MEDICAL DIRECTOR REVIEW: ☐ YES ☐ NO ☐ (SUPPORTING DOCUMENTATION ATTACHED)

MEDICAL DIRECTOR SIGNATURE:________________________________ DATE: ______________

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STAMP HERE
Non-fax date request Received

PLEASE CONTACT THE HEALTH PLAN TO VERIFY ELIGIBILITY, COVERED BENEFITS, AND OBTAIN PRIOR AUTHORIZATION AS STIPULATED IN PLAN AUTHORIZATION GUIDELINES. CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBLITY FOR DATE(S) OF SERVICE.