

# Instructions for Submitting Service Requests



## Services Requiring Authorization

The following list includes all services that require prior authorization. Any services not on this list and performed by a participating provider DO NOT require prior authorization. For your convenience, a list of procedure codes that require prior authorization can be found at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com). Select "Ohio," "Providers," "Forms." To request a hardcopy of this list, call 1-800-642-4168.

Services Requiring Prior Authorization	
<ul style="list-style-type: none"> <li>• Ambulatory surgical services                             <ul style="list-style-type: none"> <li>◦ All Non-Grouper Surgical Codes</li> <li>◦ Cosmetic/plastic procedures</li> <li>◦ Dermatologic procedures</li> <li>◦ ENT – except T &amp; A and myringotomy</li> <li>◦ Oral maxillofacial procedures</li> <li>◦ Pain management procedures, including all injections</li> <li>◦ Reductive mammoplasty</li> <li>◦ Uvulopalatopharyngoplasty (UPPP)</li> <li>◦ Visual correction surgery, blepharoplasty</li> </ul> </li> <li><i>Specific services in an office setting (place of service 11) require authorization.</i></li> <li>• Bariatric procedures and treatment related to obesity</li> <li>• Durable medical equipment – follow ODJFS guidelines</li> <li>• Experimental/investigational procedures excluded from coverage</li> <li>• Home health care</li> <li>• Home infusion</li> <li>• Selected injectable medications and immunoglobulins administered in an office, clinic or other outpatient setting. For a complete list, go to <a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a> and select Ohio, Providers, Forms, CPT Codes Requiring Authorization.</li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient admissions (skilled nursing facility, surgical, medical, obstetric, rehabilitative)</li> <li>• Radiology: MRI, MRA, PET SCAN, SPECT</li> <li>• Referrals to any non-participating providers, including second opinions</li> <li>• Transplant evaluations, transplants and related procedures</li> <li>• Behavioral Health/Chemical Dependency Providers may inquire about BH/CD services by calling Molina Healthcare of Ohio at 1-800-642-4168. Instructions for submitting BH/CD Prior Authorization Requests and the BH/CD Service Request Form are available on the Molina Healthcare website. All BH/CD services require prior authorization with the following exceptions:                             <ul style="list-style-type: none"> <li>• BH – participating psychiatrist, APRN or PCP requesting a 90801 and/or 90862 or any behavioral health service rendered at a Community Mental Health Center</li> <li>• CD - services rendered at an ODADAS facility</li> </ul> </li> </ul>
<p><b>PLEASE NOTE: Abortions, hysterectomies and sterilizations</b> do not require clinical review; however, claims for these services cannot be paid until the appropriate <b>ODJFS Consent Form</b> is received.</p>	
<p><i>Elective admissions require prior authorization. All urgent admissions require notification within 24 hours of admission or next business day.*</i></p>	

## Prior Authorization Request Submission

Submit requests for service to the Utilization Management Department by telephone, fax, mail, or via Molina Healthcare's ePortal.

<p>Telephone: <b>1-800-642-4168 (option 1, option 1)</b></p> <p>Fax: <b>1-866-449-6843</b></p> <p>Member Transportation Information: <b>1-866-642-9279</b></p>	<p>ePortal: <b><a href="http://www.MolinaHealthcare.com">www.MolinaHealthcare.com</a></b></p> <p>Mail: <b>Molina Healthcare of Ohio, Inc.</b>  <b>Attention: Service Requests</b>  <b>PO Box 349020</b>  <b>Columbus, Ohio 43234-9020</b></p>
--	---

Providers are encouraged to use the Molina Healthcare of Ohio Service Request Form or the Ohio Health Care Home Service Request Form. All requests should include the following information, as applicable, for the requested service:

Required Information for Prior Authorization Requests	
<ul style="list-style-type: none"> <li>• Member demographic information (name, DOB, social security #, etc.)</li> <li>• Provider information (referring physician and referred-to specialist)</li> <li>• Requested service/procedure, including specific CPT/HCPCS codes</li> <li>• Member diagnosis (ICD-9 code and description)</li> <li>• Location where the service will be performed</li> <li>• Requested length of stay for inpatient requests</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical indications for the service or referral, including:                             <ul style="list-style-type: none"> <li>◦ Adequate patient history related to the requested services</li> <li>◦ Physical examination that addresses the area of the request</li> <li>◦ Supporting lab and/or X-ray results to support the request</li> <li>◦ Relevant PCP and /or specialist progress notes or consultations</li> <li>◦ Any other relevant information or data specific to the request</li> </ul> </li> </ul>

Molina Healthcare of Ohio will process any non-urgent requests as quickly as possible, but no later than within 14 working days of receipt of a request. Urgent requests will be processed as soon as possible – within 72 hours of receipt of the request.

Upon **approval** the requestor will receive an authorization number by phone or fax. If a request must be denied, the requestor will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the provider by telephone or by fax with confirmation of receipt if telephonic communication fails. Verbal and fax denials are given the same business day of the denial decision. The written letter is mailed at the time the denial is issued.

## Extension of Authorization

Once a service has been authorized, the provider may call Molina Healthcare of Ohio directly to request an extension of services.

## Appeals

Details regarding the appeals process can be found in the Molina Provider Manual. Members or providers may call Member Services at 1-800-642-4168 with their appeal or submit the appeal in writing to:

**Molina Healthcare of Ohio, Attn: Member Services, PO Box 349020, Columbus, Ohio 43234-9020**

# Service Request Form (for Prior Authorization)



Service Request Identification #: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Medical Management</b>		Phone number: <b>1-800-642-4168</b> (option 1, option 1) Fax number: <b>1-866-449-6843</b>	
<b>Member Information</b>			
Member Name (Last, First, MI)		Date of Birth / /	Member I.D.
Address: (No., Street, City, State, Zip)		Phone Number: ( )	
Service Is: <input type="checkbox"/> Medically Urgent (Needed within 72 hours)* <input type="checkbox"/> Elective/Routine		Is there another insurance carrier for this service? <b>Y</b> <b>N</b> If yes, name of company:	
<b>Referral/Service Type Requested</b> <i>Please refer to the Prior Authorization List for those services that require prior authorization</i>			
<input type="checkbox"/> Inpatient Admission <input type="checkbox"/> Hospital <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Rehabilitation Facility Facility Name:  Requested Length of Stay:  Date/Time of Service:  * Requests for hysterectomies, sterilizations and abortions must be accompanied by the appropriate ODJFS form.	<input type="checkbox"/> Ambulatory surgical service <input type="checkbox"/> Bariatric procedures and treatment <input type="checkbox"/> Cosmetic/plastic procedure <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Experimental/investigational procedures <input type="checkbox"/> Home health care, home infusion <input type="checkbox"/> Injectable medications and immunoglobulins <input type="checkbox"/> Pain management <input type="checkbox"/> Radiology (MRI, MRA, PET SCAN, SPECT) <input type="checkbox"/> Referral to non-participating provider, including second opinions: <input type="checkbox"/> Transplant evaluation, procedure <input type="checkbox"/> Other: _____	# Visits requested: _____  <input type="checkbox"/> DME/supplies: _____  <input type="checkbox"/> Injectable: _____  Place of Service <input type="checkbox"/> Provider Office  <input type="checkbox"/> In Home	
<b>Referring Provider Information</b>			
Requesting Provider Name: (Last, First)		Specialty:	Phone Number:
Address: (No., Street, City, State, Zip)		Fax Number:	
Tax I.D. #:			
<b>Referred to Provider Information</b>			
Referred to Provider Name: (Physician, Facility, Agency)		Specialty:	Phone Number
Address: (No., Street, City, State, Zip)		Fax Number	
Tax I.D. #:			
<b>Clinical Information</b> (codes required)			
ICD-9 Code & description:	CPT Code & Description:	HCPC & Description:	
Clinical indications for request: (Attach pertinent clinical or progress notes and testing results):			
Requesting Provider Signature:		Date of Scheduled Service (Please include future dates, if applicable):	PCP Name:
<b>For Molina Healthcare Use Only</b>			
Service Request status: <input type="checkbox"/> Approved <input type="checkbox"/> Pending <input type="checkbox"/> Denied	Comments:		
Utilization Management Staff Signature:			Date:

\*Urgent situations are those that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of the practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.