



Behavioral Health Service Request/Notification Form

Fax to: 1-866-617-4967 Phone: 1-800-818-5837

E:Portal: www.molinahealthcare.com

Authorization#: _____ Start Date: _____ End Date: _____

(Include Authorization number on claim) *Disclaimer: Authorization numbers are not a guarantee of reimbursement of the member's medical expenses. Reimbursement is based on eligibility, medical necessity and the benefit provisions of the member's plan at the time services were rendered. *Additional limitations may apply for reimbursement of inpatient services. HHSC will pay for only 30 days of inpatient services for any patient during a particular spell of illness.

Provider Information		
Information Submitted To Molina By:	Date submitted:	
Phone Number:	Fax Number:	
Member Information		
Member Name (Last, First, MI)	Date of Birth	Member I.D.
Address: (No., Street, City, State, Zip)		Phone Number:
Minor Child: <input type="checkbox"/> Y <input type="checkbox"/> N Parent/Guardian Name (Required for Minors):		<input type="checkbox"/> Waiver (CBA)
Procedure/Service Information *CODES ARE REQUIRED		
Please attach pertinent clinical information, progress notes, and/or diagnostic tests, if not attached review will be delayed		
ICD-9 Code(s) & Description: _____ _____ _____ CPT Code(s) & Description: _____ _____ _____ HCPC Code(s) & Description: _____ _____ _____	Outpatient Procedures Only <i>*Inpatient must us Inpatient Form.</i> <input type="checkbox"/> Requesting Services <input type="checkbox"/> Submitting Notification How many sessions are you requesting: _____ How many sessions has member utilized with provider to date: _____	Current DSM-IV Diagnosis: Axis I: _____ Axis II: _____ Axis III: _____ Axis IV: _____ Axis V (current): _____ Highest level past year GAF: _____
REFERRED FROM		
Prescribing Provider/Attending Physician/Facility/Agency Name	Specialty:	
Address: (No., Street, City, State, Zip – Group Tax ID)		Fax Number:
REFERRED TO		
Prescribing Provider/Attending Physician Name	Specialty:	Phone Number
Address: (No., Street, City, State, Zip – Or Group Tax ID)		Fax Number
Comments:		

WARNING: Health care information is personal and sensitive information related to a person's health and healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require direct patient authorization. You, the recipient, are obligated to treat this document as PHI and maintain it in a safe, secure and confidential manner. Re-disclosure or unauthorized disclosure is prohibited by law and failure to protect the confidentiality of the PHI could subject to statutory penalties under state or federal law. **Important Message to the Recipient:** If you are not the intended recipient of this confidential and privileged health care information. Please notify the sender named at the top of this fax immediately. Disclosure or dissemination of this Personal Health Information is strictly prohibited by law.

Confirmed Receipt _____ Date _____ Time _____