



Notification of Authorized Services

To: _____

Company/Department: _____

Phone No./Extension: _____

Fax No: _____

From: _____

Department: **Molina Healthcare of Texas**

Phone No./Extension: **1-866-409-0039**

Fax Number: **1-866-420-3639**

Date: _____

Member Information		
Member Name (Last, First):	Date of Birth:	Medicaid #:
Address:		Phone Number:
Units per week 12rs:	Days per week:	Modifier:
Diagnoses:		Auth Period:
Tasks: <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Exercise <input type="checkbox"/> Feeding <input type="checkbox"/> Grooming <input type="checkbox"/> Hair/Skin Care <input type="checkbox"/> Toileting <input type="checkbox"/> Transfer/Ambulation <input type="checkbox"/> Cleaning <input type="checkbox"/> Laundry <input type="checkbox"/> Meal Prep <input type="checkbox"/> Escort <input type="checkbox"/> Shopping <input type="checkbox"/> Med Reminder		
Comments		Authorization Number *

* This reference/authorization number is not a guarantee of reimbursement or of the patient's medical expenses. Reimbursement is based on the eligibility, medical necessity and benefit provisions of the patient's plan at the time services were rendered.

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