



DATE: \_\_\_\_\_  
**THIS REFERRAL IS VALID FOR 30 DAYS ONLY**

**MOLINA HEALTHCARE OF CALIFORNIA  
 DIRECT REFERRAL TO SPECIALIST**

**DIRECT REFERRALS ARE ONLY VALID TO A MOLINA HEALTHCARE CONTRACTED SPECIALIST**

PATIENT NAME:	MEMBER ID:
Date of Birth (mm/dd/yyyy):	Address:
Phone Number:	
<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medicare <input type="checkbox"/> Dual Options <input type="checkbox"/> Marketplace	
Referred To:	Specialty:
Phone Number:	Address:
Fax Number:	
Diagnosis:	ICD-10 Code:
<b>ATTACH ALL NECESSARY CLINICAL INFORMATION TO THIS DIRECT REFERRAL</b>	
Referring PCP:	Specialty:
Phone Number:	Address:
Fax Number:	

**PLEASE NOTE: SPECIALISTS ARE REQUIRED TO SUBMIT REPORTS BACK TO THE REFERRING PCP**

**INSTRUCTIONS:**

- Provide completed original form to Molina Healthcare member to be presented to Specialist.
- Forward a copy to referred Specialist.
- Place a copy in the Molina Healthcare member’s medical record.

All out-of-network services require Prior Authorization (PA). Initial specialty consults and follow-ups for Bariatric Surgery, Reconstructive or Cosmetic Surgery require PA. All other requests for initial specialty consults and follow-ups to contracted providers do not require PA.