



Medi-Cal & HF Prior Authorizations:
Phone: 800-526-8196 ext. 126400
Fax: 800-811-4804

Medicare Prior Authorization:
Phone: 800-526-8196 ext. 129105
Fax: 866-472-0596

Tracking#: _____
Please include Tracking number on claim.
Expiration Date: _____

SERVICE REQUEST FORM

PRODUCT: <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> HEALTHY FAMILIES <input type="checkbox"/> MEDICARE		
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. MHC reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date: ____/____/____
Member Name (Last, First, Middle Initial)		Date of Birth ____/____/____
Mem I.D.(Social Security Number) ____-____-____		
Address (No., Street, City, State, Zip)		Phone Number: (____) ____-____
Referral/Service Type Requested		
<input type="checkbox"/> Specialist Consult/Tx/FU Care	<input type="checkbox"/> Surgical Procedure	Requested LOS: _____
<input type="checkbox"/> Inpatient Admission	<input type="checkbox"/> Inpatient	Facility: _____
<input type="checkbox"/> Major Diagnostic Procedure	<input type="checkbox"/> Outpatient	Date/Time of Service: _____
<input type="checkbox"/> Home Health	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other: _____
<input type="checkbox"/> DME (refer to PA list)	<input type="checkbox"/> Comments: _____	
Requesting Provider Information		Referring To Provider Information
Requesting provider name (last, first)		Referring to provider name (physician, mg/ipa, facility, agency)
Address: (No., Street, City, State, Zip)		Address: (No., Street, City, State, Zip)
Specialty		Specialty
Phone Number (____) ____-____		Phone Number (____) ____-____
Fax number (____) ____-____		Fax number (____) ____-____
Service Request Information		
ICD-9 Code #/Description:	Code or Description:	
Clinical indications for request: (include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results, etc)		
Requesting Practitioner Signature:		Date: ____/____/____
MOLINA Use Only		
Criteria/guidelines met: <input type="checkbox"/> yes <input type="checkbox"/> no		Authorization Status: <input type="checkbox"/> approved <input type="checkbox"/> modified <input type="checkbox"/> deferred <input type="checkbox"/> denied
Comments:		
UM representative signature:		Date: ____/____/____
Approved LOS:		
MEDICAL DIRECTOR REVIEW		
<input type="checkbox"/> APPROVED	COMMENTS:	
<input type="checkbox"/> MODIFIED		
<input type="checkbox"/> DENIED		
MEDICAL DIRECTOR SIGNATURE: _____		Date: ____/____/____

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CLAIMS PAYMENT IS CONTINGENT ON MEMBER ELIGIBILITY FOR DATE(S) OF SERVICE

MOLINA
FORM: 1451
REV 10/17/2012