MOLINA HEALTHCARE

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

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

SERVICE REQUEST FORM

PRODUCT: ☐ MEDI-CAL ☐ HEALTHY FAMILIES ☐ MEDICARE

Service is: ☐ **NON-URGENT** ☐ **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

☐ Specialist Consult/Tx/FU Care	☐ Surgical Procedure	Requested LOS:_____
☐ Inpatient Admission	☐ Inpatient	Facility: _____
☐ Major Diagnostic Procedure	☐ Outpatient	Date/Time of Service: _____
☐ Home Health	☐ Hospice	☐ Other: _____
☐ DME (refer to PA list)	☐ 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: ☐ yes ☐ no Authorization Status: ☐ approved ☐ modified ☐ deferred ☐ denied

Comments:

UM representative signature:	Date:	Approved LOS:

MEDICAL DIRECTOR REVIEW

☐ APPROVED	COMMENTS:
☐ MODIFIED	
☐ DENIED	

MEDICAL DIRECTOR SIGNATURE: _____ Date: _____/_____/_____

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

MOLINA
FORM: 1451
REV 10/17/2012