



Molina Healthcare of Michigan Prior Authorization Request Form



Phone Number: (888) 898-7969

Medicaid Fax Number: (800) 594-7404

Medicare Fax: (888) 295-7665

Member Information

Plan: Molina Medicaid Molina MIChild Molina Medicare Other: _____

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone #: _____ () _____

Service Is: Elective/Routine Expedited/Urgent*

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Referral/Service Type Requested		
Inpatient <input type="checkbox"/> Surgical Procedures <input type="checkbox"/> ED Admission <input type="checkbox"/> Direct Admission <input type="checkbox"/> SNF <input type="checkbox"/> Rehab <input type="checkbox"/> LTAC	Outpatient <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Rehab (PT, OT, & ST) <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> Imaging <input type="checkbox"/> Chiropractic <input type="checkbox"/> Wound Care <input type="checkbox"/> Infusion Therapy	<input type="checkbox"/> DME <hr/> <input type="checkbox"/> Home Health <hr/> <input type="checkbox"/> In Office

Referred To Provider/Facility Name & Tax ID#: _____

Referred To Address & Phone#: _____

Diagnosis Code & Description: _____

CPT/HCPCS Code & Description: _____

Number of visits requested: _____ Date(s) of Service: _____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name and Address: _____

Contact @ Requesting Provider's: _____

Phone Number: _____ () _____ Fax Number: _____ () _____

For Molina Use Only: