Molina Healthcare / Molina Medicare Prior Authorization Request Form

Phone Number: (877) 262-0187
Fax Number: (888) 802-5711

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Other:**_____

Member's Name:_____ DOB: ____/____/____

Member's 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 enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine / non-urgent.**

Referral / Service Type Requested		
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office**

ICD-9 Code & Description: _____

CPT/HCPC Code & Description: _____

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

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name:_____

Facility Providing Service:_____

Contact @ Requesting Provider's: _____

Phone Number: _____ Fax Number: _____

For Molina Use Only: