Molina Healthcare/Molina Medicare Prior Authorization Request Form

Phone Number: (888) 483-0760
Medicaid/CHIP Fax Number: (866) 472-0589
Medicare Fax Number: (866) 504-7262

Member Information

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

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

Member's ID#:_____ Member Phone #: (___)_____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent **(See Definition if Selecting)**

Definition: Treatment requested is to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function.
If request is outside of this definition it should be submitted as Elective/Routine.

***Required Information to Process Request**

Referral/Service Type Requested*			
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ PT, OT, & ST ☐ Imaging ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	**Mental Health** ☐ Inpatient ☐ PHP ☐ IOP ☐ Chemical Dependency ☐ Office Visits	**Home Health** ☐ Skilled Services (SN/PT/OT/ST) ☐ Custodial/Supportive (HHA) ☐ Home Infusion **DME** ☐ Wheel Chair - Purchase/Repair ☐ Enteral Formula/Supplies ☐ Prosthetic/Orthotic ☐ **In Office Procedure**

Procedure Information	
ICD-9 Code & Description*:	
CPT/HCPC Code & Description*:	
Number of visits requested*:	**DOS*:**

Ordering/Referring Physician Information		
Name*:		**Contact Name:**
Address:		
TIN/NPI*:	**Phone #*:**	**Fax #*:**

Rendering Facility/Provider Information		
Name*:		
Address:		
TIN/NPI*:	**Phone #*:**	**Fax #*:**

*** <u>Clinical notes and supporting documentation is required to review for medical necessity</u>***

For Molina Use Only: