MOLINA HEALTHCARE
Your Extended Family.

# Molina Healthcare – Prior Authorization Service Request Form

## MEMBER INFORMATION

| | | | | |
|---|---|---|---|---|
| **Line of Business:** | ☐ **Medicaid** | ☐ **Marketplace** | ☐ **Medicare** | **Date of Request:** |
| **State/Health Plan (i.e. CA):** | | | | |
| **Member Name:** | | | **DOB** (MM/DD/YYYY): | |
| **Member ID#:** | | | **Member Phone**: | |
| **Service Type:** | ☐ Non-Urgent/Routine/Elective<br>☐ Urgent/Expedited – Clinical Reason for Urgency **Required**:_____<br>☐ Emergent Inpatient Admission<br>☐ EPSDT/Special Services | | | |

## REFERRAL/SERVICE TYPE REQUESTED

| | | | |
|---|---|---|---|
| **Request Type:** | ☐ **Initial Request** | ☐ **Extension/ Renewal / Amendment** | **Previous Auth#:** |

| **Inpatient Services:** | **Outpatient Services:** | | |
|---|---|---|---|
| ☐ Inpatient Hospital | ☐ Chiropractic | ☐ Office Procedures | ☐ Pharmacy |
| ☐ Inpatient Transplant | ☐ Dialysis | ☐ Infusion Therapy | ☐ Physical Therapy |
| ☐ Inpatient Hospice | ☐ DME | ☐ Laboratory Services | ☐ Radiation Therapy |
| ☐ Long Term Acute Care (LTAC) | ☐ Genetic Testing | ☐ LTSS Services | ☐ Speech Therapy |
| ☐ Acute Inpatient Rehabilitation (AIR) | ☐ Home Health | ☐ Occupational Therapy | ☐ Transplant/Gene Therapy |
| ☐ Skilled Nursing Facility (SNF) | ☐ Hospice | ☐ Outpatient Surgical/Procedures | ☐ Transportation |
| ☐ Other Inpatient:_____ | ☐ Hyperbaric Therapy | ☐ Pain Management | ☐ Wound Care |
| | ☐ Imaging/Special Tests | ☐ Palliative Care | ☐ Other: _____ |

## PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

**Primary ICD-10 Code:** **Description:**

| DATES OF SERVICE START | STOP | PROCEDURE/ SERVICE CODES | DIAGNOSIS CODE | REQUESTED SERVICE | REQUESTED UNITS/VISITS |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
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## PROVIDER INFORMATION

### REQUESTING PROVIDER / FACILITY:

| | | | |
|---|---|---|---|
| **Provider Name:** | **NPI#:** | **TIN#:** | |
| **Phone**: | **FAX**: | **Email**: | |
| **Address:** | **City:** | **State:** | **Zip:** |
| **PCP Name:** | **PCP Phone**: | | |
| **Office Contact Name:** | **Office Contact Phone**: | | |

### SERVICING PROVIDER / FACILITY:

| | | | | |
|---|---|---|---|---|
| **Provider/Facility Name (Required):** | | | | |
| **NPI#:** | **TIN#:** | **Medicaid ID# (If Non-Par):** | ☐ **Non-Par** | ☐ **COC** |
| **Phone**: | **FAX:** | **Email:** | | |
| **Address:** | **City:** | **State:** | **Zip:** | |

**For Molina Use Only:**

*Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.*