MOLINA HEALTHCARE | Molina Complete Care

Behavioral health psychological/neuropsychological prior authorization form

Member information

Plan: ☐ Medicaid ☐ D-SNP

Date of request:

Member name: DOB:

Member ID# Member phone #:

Services is: ☐ Standard/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.

Provider information

Requesting provider/facility/clinic name and address: _____

Servicing provider/facility/clinic name and address: _____

Servicing provider NPI _____ Servicing provider tax ID# _____

UR contact name: _____ UR phone#/fax: _____

Servicing provider status: ☐ PAR ☐ Non-PAR

Service request information

Dates of service requested: _____

Primary diagnosis: _____ Additional diagnoses: _____

Initial evaluation completion date: _____ Completed by: _____

Service request information:

CPT/HCPCS code	Test to be administered	Time for administration/units requested

Specific diagnostic or treatment related question the testing is intended to answer:

_____

Member is able to participate in the testing? ☐ Yes ☐ No

Parent/guardian is able to contribute? ☐ Yes ☐ No ☐NA

How will this testing impact the treatment plan? _____

Please be sure to attach clinical information related to this request and fax to (888) 656-7501.