



<div>Molina Healthcare of California</div> <div>COMMUNITY BASED ADULT SERVICES (CBAS) REQUEST FOR SERVICES</div> <div>Please fax the completed form to <b>Molina Healthcare of California CBAS at 1-800-811-4804</b>, if you have questions may call our Molina Utilization Management Department (844) 557-8434</div>				
DATE:		PCP:		
REFERRING PHYSICIAN INFORMATION				
REFERRING PHYSICIAN:		REFERRING PHYSICIAN NPI NUMBER:		REFERRING PHYSICIAN PHONE NUMBER:
REFERRING PHYSICIAN ADDRESS:				REFERRING PHYSICIAN FAX NUMBER:
PATIENT INFORMATION				
MEMBER NAME:		GENDER:	DOB:	AGE: MEMBER ID (Medi-Cal/CIN):
ADDRESS:		PHONE NUMBER:		ALTERNATE NUMBER:
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) Enter Name and Address			Preferred Language:	
REFERRAL - SERVICE TYPE REQUESTED				
<input type="checkbox"/> Expedited Referral for Post Hospitalization/SNF stay	<input type="checkbox"/> Initial CBAS Services  <input type="checkbox"/> Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)		<input type="checkbox"/> Modification of Days for IPC	
CBAS CENTER SUBMITTING THIS REQUEST				
PROVIDER NAME or Specify DBA:		PROVIDER NPI NUMBER:		PHONE NUMBER:
ADDRESS:				FAX NUMBER:
DIAGNOSIS/PROCEDURE INFORMATION				
ICD-10 CODE(S) /DESCRIPTION:		CPT CODE(S)/DESCRIPTION:		HCPCS /DESCRIPTION:
MEDICAL JUSTIFICATION – Include pertinent information regarding IPC (i.e. past medical treatment, physical findings and attach all relevant medical records, test results, etc.):				
DATES AND SPECIFIC SERVICES REQUESTED		DAY'S PER WEEK		QUANTITY/UNITS
REQUESTING PROVIDER (PRINT):		SIGNATURE:		DATE:
Criteria/guidelines Met: <input type="checkbox"/> yes <input type="checkbox"/> no		Authorization Status: <input type="checkbox"/> approved <input type="checkbox"/> modified <input type="checkbox"/> deferred <input type="checkbox"/> denied		Authorization Number:
Comments:				

**Confidentiality Notice:** This fax transmission, including any attachments, contains confidential information that maybe privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon the fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents.

THIS REFERRAL IS VALID FOR 30 DAYS ONLY

Form Revised: 11/15/2024