Molina Healthcare of California

COMMUNITY BASED ADULT SERVICES (CBAS) REQUEST FOR SERVICES

*Please fax the completed form to **Molina Healthcare of California CBAS at 1-800-811-4804**, if you have questions may call our Molina Utilization Management Department (844) 557-8434*

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				
☐ **Expedited Referral for Post Hospitalization/SNF stay**	☐ **Initial CBAS Services** ☐ **Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)**			☐ **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: ☐ yes ☐ no	**Authorization Status:** ☐ approved ☐ modified ☐ deferred ☐ denied	**Authorization Number:**
Comments:		

THIS REFERRAL IS VALID FOR 30 DAYS ONLY

Form Revised: 11/15/2024