



**MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW
GUIDE EFFECTIVE: 01/01/2026**

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization

Only covered services are eligible for reimbursement

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS

DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

ALWAYS REQUEST SERVICES FROM PRIMARY INSURANCE CARRIER BEFORE SECONDARY MEDICAID, UNLESS MEDICAID WAIVERED SERVICE OR NON-COVERED MEDICARE SERVICE.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient, Residential Treatment, require notification and subsequent concurrent review.
 - Electroconvulsive Therapy (ECT)
 - Applied Behavioral Analysis (ABA)– for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology¹:** For adults select services are administered by New Century Health (NCH).
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (per State benefit).** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **Non-Par Providers:** With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
 - Local Health Department (LHD) services
 - Hospital Emergency services
 - Evaluation and Management services associated with inpatient, ER, and observation stays or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
 - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24, 51, 52
 - Other State mandated services

- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Oncology**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow**
(Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

IMPORTANT INFORMATION FOR MOLINA MEDICAID PROVIDERS

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1 (855) 322-4081.

Molina will make a decision within the following timeframes:

Expedited (Urgent)	Standard (Non-Urgent)
72 Hours	7 Calendar Days

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-5pm local M-F, unless otherwise specified)

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with the claim.

Prior Authorizations including Behavioral

Health Authorizations:

Phone: 1 (855) 322-4081

Pharmacy Authorizations:

Phone: 1 (855) 322-4081

Fax: 1 (866) 497-7448

Radiology Authorizations:

Phone: (855) 714-2415

Provider Customer Service:

Phone: 1 (855) 322-4081

Member Customer Service, Benefits/ Eligibility:

Phone: (888)483-0760/ TTY/TDD 711

Transportation:

Phone: 1 (801) 538-6155

Transplant Authorizations:

Phone: (855) 714-2415

Fax: (877) 813-1206

24 Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750/TTY: 711

Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members. No referral or prior authorization is needed.

Providers may utilize Molina Healthcare's Website at:

<https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report

Molina® Healthcare, Inc. - Prior Authorization Request Form

MEMBER INFORMATION

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

Referral/Service Type Requested

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension / Renewal / Amendment	Previous Auth#:
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Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Rate code 17 Waived Service Nursing Facility LTC *verify PASRR submitted to state	<input type="checkbox"/> DME <input type="checkbox"/> Hospice	<input type="checkbox"/> LTSS Services - Do not use this form. Email MHIDCaseManagement@molinahealthcare.com if you are unsure of how to request rate code 15 services.	<input type="checkbox"/> Transportation <input type="checkbox"/> Other: _____
<input type="checkbox"/> Other Inpatient: _____			

Please send clinical notes and any supporting documentation

Primary ICD-10 Code:	Description:			
Dates of Service Start	Procedure/Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

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):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Phone:	FAX:	Email:	
Address:	City:	State:	Zip:

For Molina Use Only:			
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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.