



Molina Healthcare of Illinois Behavioral Health Prior Authorization Request Form

MMP/Medicaid Phone: (855) 866-5462	Medicaid Fax: (866) 617-4971	MMP - Inpatient Fax: (844) 834-2152	MMP - Outpatient Fax: (844) 251-1451	Non-Emergent Transportation: MTM Phone: (844) 644-6354 MTM Fax: (877) 406-0658
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Member Information			
Illinois LOB	<input type="checkbox"/> Molina Medicaid	<input type="checkbox"/> Molina MMP Dual Options	<input type="checkbox"/> Molina Marketplace
Member Name:	DOB:		Today's Date:
Member ID:	Member Phone Number:		
Service Type	<input type="checkbox"/> Non-Urgent/Elective/Routine Determination within four (4) calendar days from receipt of all necessary information.	<input type="checkbox"/> Expedited/Urgent Clinical Reason: _____	
	<input type="checkbox"/> Emergent Inpatient Admission	I certify the request is urgent and medically necessary to treat an injury, illness, or condition (not life-threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.	

*** 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**

Referral/Service Type Requested		
Request Type	<input type="checkbox"/> Initial Request/New Admission	<input type="checkbox"/> Extension/Renewal/Concurrent Auth No:
Inpatient Services	Outpatient Services	
<input type="checkbox"/> Inpatient Psychiatric: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Inpatient Detox, BH Unit <input type="checkbox"/> Residential Treatment (ASAM 3.5) <input type="checkbox"/> Subacute Detoxification (ASAM 3.7)	<input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other:

***** Clinical notes and supporting documentation are required to review for medical necessity. *****

Primary ICD-10 Code for Treatment, With Description				
Dates of Service Start Stop	Procedure/Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

Requesting Provider Information	
*Name/Credentials:	IL Medicaid Certified <input type="checkbox"/> Yes <input type="checkbox"/> No
*Address:	Contact Name:
*Billing NPI:	*Phone No.: ()
*Billing TIN:	*Fax No.: ()
Servicing Provider / Facility Information	
*Name:	IL Medicaid Certified <input type="checkbox"/> Yes <input type="checkbox"/> No
*Address:	Contact Name:
*Servicing NPI:	*Phone No.: ()
*Servicing TIN:	*Fax No.: ()

***ALL REQUIRED FIELDS—MUST BE COMPLETED. INCOMPLETE FORMS WILL BE REJECTED.**

For Molina Use Only:

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be covered Health Plan Benefit and medically necessary with prior authorization as per plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

By requesting prior authorization, the provider is affirming that the services are medically necessary; a covered benefit under the Medicare and/or Medicaid Program(s), and the servicing provider is enrolled in those programs as eligible for reimbursement. As a condition of authorization, for services that are primary to Medicare, the out-of-network provider agrees to accept no more than 100% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the Date(s) of Service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member was enrolled in the Medicare Fee-For-Service Program. If the service is primary to Medicaid, the out-of-network provider agrees to accept no more than the amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of Illinois in effect on the Date(s) of Service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Molina Healthcare will not reimburse providers for services that are not deemed medically necessary. Servicing providers also recognize that Molina Healthcare members are not to be balanced billed for any uncollected monies for covered services pursuant to Medicare and Medicaid billing guidelines.