PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Passport Health Plan by Molina Healthcare Cosmetic & Reconstructive Surgery Request Form

For Date of Service Change please complete areas marked with only**

Member Name** ____________________ **Member ID**** ________________ **Member DOB** ___________

Requesting physician / Provider**

Rendering Provider Name ____________________________ **Tax ID** ____________________________

Phone _____________________________________ **Fax** _____________________________________

MD Name	
MD Phone	
MD Fax	

Inpatient ☐ **Outpatient** ☐ **Observation** ☐

CLINICAL INFORMATION

DATE OF SERVICE**

PROCEDURE:

CPT	Description

PREVIOUS ASSOCIATED SURGERIES:

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.

CLINICAL SUMMARY:

Clinical information and supportive documentation should consist of current physician order, relevant notes supporting the request and recent diagnostics. To determine Medical Necessity, in conjunction with independent professional medical judgment, Passport uses nationally recognized evidence-based guidelines (MCG), third party guidelines, CMS guidelines, state/commonwealth guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

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