PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Passport Health Plan by Molina Healthcare Medical Inpatient Request Form

Member Name _____ **Member ID** _____ **Member DOB** _____

Admission Date: _____ **Scheduled** ☐ **Emergent / Urgent** ☐

Requesting physician / Provider

Rendering Provider Name _____ **Tax ID** _____

Phone _____ **Fax** _____

MD Name	
MD Phone	
MD Fax	

Has member been discharged? YES ☐ **NO** ☐ **If yes, Discharge Date:**

Discharge Disposition (Check One)

Home		**Home Health**	
Rehab		**Expired**	
LTACH		**Other**	

Anticipated Discharge Needs

Home Health	
Therapy	
DME	
Other – Specify	

Does the member require Case Management Referral or Intervention ?
☐ **YES** ☐ **NO**

Please Provide Discharge Plan with documentation

CLINICAL INFORMATION AND CLINICAL SUMMARY

DIAGNOSIS

ICD10	Description

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.

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PROCEDURES If applicable

CPT	Description

Presenting Signs and Symptoms

RADIOLOGIC STUDIES: (Include dates and results)

Study	Date	Result

ABNORMAL LABS:

Lab	Date	Result

Clinical information and supportive documentation should consist of current physician order, relevant notes supporting the request and recent diagnostics / consultations. 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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