

Molina[®] Healthcare, Inc. – BH Prior Authorization Request Form

Requests for prior authorization should be sent via the [Availity Essentials portal](#).

- Claims Submission and Status
- Authorization Submission and Status
- Member Eligibility

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Duals	<input type="checkbox"/> Medicare	<input type="checkbox"/> CA EAE (Medicaid)	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 <input type="checkbox"/> Inpatient ER Admission (Concurrent) <input type="checkbox"/> EPSDT/Special Services <input type="checkbox"/> CA IPA request: Medicare Denial, requires Medicaid Review			<input type="checkbox"/> Continuity of Care (COC)

REFERRAL/SERVICE TYPE REQUESTED

Line of Business:	<input type="checkbox"/> Duals	<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"/> Other (Please Specify): <input type="checkbox"/> Inpatient ER Admission (Concurrent)		

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/Renewal/Amendment	<input type="checkbox"/> Previous Auth #
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary If Involuntary, Court Date:	<input type="checkbox"/> Residential Treatment <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:_____	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: Description:

DATES OF SERVICE		PROCEDURE/SERVICES CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
Start	Stop				

PROVIDER INFORMATION

Requesting/Referring Provider/Facility:				
Provider Name:		NPI#:	TIN#:	
Phone:	Fax:		Email:	
Address:	City:	State:	Zip:	
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		
Servicing/Billing 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:	

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