Molina Healthcare – Behavioral Health Prior Authorization Request Form
Phone: 855-322-4077

Member Information

Member Name:		**DOB**:
Member ID#:		**Member Phone**:
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited	

Service Requested

Outpatient Services:

☐ Applied Behavioral Analysis
☐ Electroconvulsive Therapy
☐ Non-PAR Outpatient Services
☐ Psychological/Neuropsychological Testing
☐ Other: _____

☐ **Continuation of Care (COC)** – Non par provider requesting services for COC

Note:

Inpatient Psychiatric and Detoxification services are rendered through the PIHPs.

Outpatient Treatment, Partial Hospitalization, Intensive O/P, Day Treatment and Assertive Community Treatment Programs are rendered through the PIHPs.

Date of Service	Diagnosis Code	Procedure/HCPC Code	Service Description	Requested Units/Visits

Provider Information

Requesting Provider/Facility: (Decision will be sent to the requesting provider/facility)				
Provider Name:	**NPI#:**		**TIN#:**	
Phone:	**Fax:**			
Address:	**City:**		**State:**	**Zip:**
Office Contact Name:		**Office Contact Phone**:		

Servicing Provider/Facility:				
Provider/Facility Name:	**NPI#:**		**TIN#:**	
Phone:	**Fax:**			
Address:	**City:**		**State:**	**Zip:**

For Transcranial Magnetic Stimulation (TMS) requests, please also indicate the following:

☐ No presence of acute or chronic psychotic symptoms or disorders (i.e., schizophrenia or schizoaffective disorder)

☐ No cochlear implant or deep brain stimulator

☐ No metallic hardware or implanted magnetic-sensitive medical device implanted within 30cm of the discharging coil

☐ Treatment parameters use either high frequency or low frequency (less than 1 Hz to 20 Hz) and taper over course of treatment

☐ Request is for a continuation course of treatment after an acute treatment course

Medication history including adherence, duration and side effects must be included with request