Molina Healthcare – 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

Inpatient Services:	**Outpatient Services:**		
☐ Surgical Procedure ☐ Transplant	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Genetic Testing ☐ Home Health ☐ Hyperbaric Therapy ☐ Imaging/Special Tests ☐ Infusion Therapy ☐ Non-Par Provider Request ☐ Occupational Therapy	☐ Office Procedures ☐ Pain Management ☐ Physical Therapy ☐ Radiation Therapy ☐ Sleep Study ☐ Speech Therapy ☐ Surgical Procedures ☐ Transplant ☐ Wound Care ☐ Other: _____	☐ **Continuation of Care (COC)** – Non par provider requesting services for COC ☐ **Home care** - Eval + 6 visits have been used this calendar year ☐ **PT/OT/ST** – Eval + 12 visits have been used this calendar year ☐ **PT/OT/ST** – Provider accepts 8 visits

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:**

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.