MOLINA® HEALTHCARE MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 04/01/2020
FAX (866) 423-3889 PHONE (855) 237-6178

MEMBER INFORMATION

Plan:	☐ **Healthy Connections Medicaid**		
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐Elective/Routine	☐Expedited/Urgent*	

***Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

REFERRAL/SERVICE TYPE REQUESTED

Inpatient	**Outpatient**	
☐Surgical procedures ☐NICU ☐Admissions ☐SNF ☐Rehab ☐LTAC ☐PRTF	☐Surgical Procedure ☐Pre-Procedure Testing ☐OT ☐PT ☐ST ☐Diagnostic Procedure ☐Hyperbaric Therapy ☐Infusion Therapy ☐Pain Management ☐Behavioral Health/ASD/RBHS ☐Dental Procedure ☐Other: _____	☐ **Home Health** ☐ **DME** ☐ **Wheelchair** ☐ **In Office**

Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		DOS From: / / to / /	
Number of visits or units used since 7/1 of the previous year (as applicable)	☐Visits: ☐Units:	PT OT Speech	

J Code Drug Requests (Include J Code, Drug Name, Dosage, and Frequency):

J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION

Requesting/Ordering Provider Name:		NPI#:		TIN#:	
Provider or Facility Providing Service:		NPI#:		TIN#:	
Contact at Requesting Provider's office:					
Phone Number:	( ) -	Fax Number:	( ) -		

For Molina Use Only:

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.