Molina® Healthcare Medicaid Prior Authorization/Pre-Service Review Guide Effective: 01/01/2026

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization
Only covered services are eligible for reimbursement

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION.
EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Residential Treatment, require notification and subsequent concurrent review.
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology**
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing** (Except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns or as otherwise mandated by state regulations).
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (per State benefit).** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **Non-Par Providers:** With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
  - Local Health Department (LHD) services
  - Hospital Emergency services
  - Evaluation and Management services associated with inpatient, ER, and observation stays or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
  - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24, 51, 52
  - Other State mandated services
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy**
- **Oncology**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies:**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with the claim.

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICAID PROVIDERS

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.

The Urgent/Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine/non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.

  Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 1 (855) 322-4081.

Molina will make a decision within the following timeframes:

Expedited (Urgent)	**Standard** (Non-Urgent)
72 Hours	7 Calendar Days

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-5pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health Authorizations:
Phone: 1 (855) 322-4081

Pharmacy Authorizations:
Phone: 1 (855) 322-4081
Fax: 1 (866) 497-7448

Radiology Authorizations:
Phone: (855) 714-2415

Provider Customer Service:
Phone: 1 (855) 322-4081

Member Customer Service, Benefits/Eligibility:
Phone: (888)483-0760/ TTY/TDD 711

Transportation:
Phone: 1 (801) 538-6155

Transplant Authorizations:
Phone: (855) 714-2415
Fax: (877) 813-1206

24 Hour Nurse Advice Line (7 days/week)
Phone: (888) 275-8750/TTY: 711
Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/ Spanish speaking members. *No referral or prior authorization is needed.*

Providers may utilize Molina Healthcare's Website at:
https://provider.MolinaHealthcare.com/Provider/Login
Available features include:

- Authorizations submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report

Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., CA):				
Member Name:		**DOB** (MM/DD/YYYY):		
Member ID#:		**Member Phone:**		

Service Type:

☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited – Clinical Reason for Urgency **Required**: _____
☐ Emergent Inpatient Admission
☐ EPSDT/Special Services

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ **Initial Request** ☐ **Extension / Renewal / Amendment** **Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy **Use Pharmacy form unless TPN**
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Physical Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Radiation Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Speech Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/ Procedures	☐ Transplant/Gene Therapy
☐ Other Inpatient: _____	☐ Hyperbaric	☐ Pain Management	☐ Transportation
	☐ Therapy Imaging/ Special Tests	☐ Palliative Care	☐ Wound Care
			☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

Dates of Service Start	Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

Requesting Provider/Facility

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**
PCP Name:	**PCP Phone:**		
Office Contact Name:	**Office Contact Phone:**		

Servicing Provider/Facility

Provider/Facility Name (Required):				
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐ **Non-Par**	☐ **COC**
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	

For Molina Use Only:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

Molina® Healthcare, Inc. - BH Pre-Service and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e., CA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone:**	

Service Type:
☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited –
Clinical Reason for Urgency **Required**: _____
☐ Emergent Inpatient Admission

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ **Initial Request** ☐ **Extension / Renewal / Amendment** **Previous Auth#:**

Inpatient Services:

☐ Inpatient Psychiatric
☐ Involuntary ☐ Voluntary
☐ Inpatient Detoxification
☐ Involuntary ☐ Voluntary
If Involuntary, Court Date:
_____

Outpatient Services:

☐ Residential Treatment
☐ Day Treatment
☐ Assertive Community Treatment Program
☐ Targeted Case Management

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

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

Dates of Service Start	Dates of Service Stop	Procedure/ Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

Requesting Provider/Facility

Provider Name:	**NPI#:**	**TIN#:**	
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**
PCP Name:	**PCP Phone:**		
Office Contact Name:	**Office Contact Phone:**		

Servicing Provider/Facility

Provider/Facility Name (Required):

NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐ **Non-Par**	☐ **COC**
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	

For Molina Use Only:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

Molina Healthcare of Utah
Medicaid/CHIP
Fax: (866) 497-7448
Phone: (855) 322-4081

Medical Benefit (HCPCS/J-Code) Drug Prior Authorization Request Form

*****This form is intended for OUTPATIENT requests and chart note documentation is required.**

***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 member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent**

MEMBER INFORMATION						
Member Name:				**Date of birth:**	/ /	
Member ID#:				**Phone:**	( ) -	
Service Type:	Elective/Routine	Expedited/Urgent*	NEW	REAUTH	**Date of Request:**	/ /

PROVIDER INFORMATION			
Requesting Provider Name and specialty:		**NPI#:**	**Office contact:**
Provider Phone Number:	( ) -	**Provider Fax Number:**	( ) -
Servicing Provider or Facility:		**Facility NPI#:**	
Facility Phone Number:	( ) -	**Facility Fax Number:**	( ) -

DRUG/SERVICE REQUESTED			
Diagnosis Code & Description:	**Number of visits requested:**	**Dates of Service from: / / to / /**	
J Code:	**J Units:**	**Name of Medication:**	**Strength/Quantity:**
Dosage & Frequency:	**Duration of Therapy:**	**National Drug Code (NDC) and Unit of Measure:**	

PREVIOUS DRUG TRIALS
** Please include trial dates and details of failure. These must be supported by claim history or chart note documentation. Use of drug samples cannot be accepted as justification**

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.

Prescriber Signature: **Date:**