Molina Complete Care

Request for Prior Authorization

Molina Complete Care is your partner in providing care.
In order to efficiently process your authorization request, fields marked with * must be completed.

Member Information:

*Full Name: ______________________ Height __________ Weight __________
Address: ______________________
Telephone #: (_____)______________ *DOB: ____/____/______ *Medicaid #: ______________
Emergency/Legal Guardian Contact Person: ______________ Telephone #: ______________

Request Type: *Physical Health* ☐ *Behavioral Health* ☐

☐ Out of Network - If Out of Network, reimbursement will be at DMAS Medicaid Rates - Accept: Yes ☐ No ☐
☐ Standard/Routine
☐ Concurrent
☐ Expedited
☐ Retrospective* For inpatient medical/behavioral related to inability to verify insurance coverage timely (up to 5 days post discharge)

**** Expedited 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. Request outside of this definition should be submitted as one of the other options.***

Inpatient Services	Outpatient Services	Additional Services
☐ Surgical Procedure	☐ Surgical Procedure	☐ Skilled Home Care Services
☐ Hospitalization	☐ Infusion Therapy	☐ Private Duty Nursing
☐ SNF	☐ OT/PT/ST	☐ DME Purchase
☐ Custodial NF	☐ Personal Care	☐ DME Rental
☐ LTACH	☐ Respite Services	☐ J-Codes *(Authorized up to 6 months at a time.)*
☐ Hospice (inpatient)	☐ Hospice (outpatient)	☐ Other______________
☐ Inpatient Rehabilitation	☐ Other______________	
☐ Long Stay Hospital		
☐ TDO/ECO		

*Requested Diagnosis Code: ______________________
*Requested CPT/HCPCS Code: ______________________
*Requested Number of Visits: ______________ *DOS From: ____/____/____ to ____/____/____
*Frequency of Service: *(Detailed)* ______________________

Indicate the # of units, visits, or hours being requested daily, weekly or monthly as pertained to service requested. (i.e.:3 visits/week; 8 hrs/day).

J Code				
Drug Name/ Strength				
Dose				
Route				
Frequency				
Total Doses				

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION WITH THIS REQUEST FORM

Requesting Provider:

*Name: ______________________
*Provider ID #: ______________________
TIN/NPI #: ______________________
Telephone #: ______________________
*Fax #: ______________________
*Contact Name/Phone #: ______________________

Servicing Provider/Facility:

*Name: ______________________
*Provider ID that claim will be billed with: ______________________
TIN/NPI #: ______________________
Telephone #: ______________________
*Fax #: ______________________
*Contact Name/Phone #: ______________________
*Address to mail letter: ______________________

Submitted By: ______________________ (Please Print) Date: ____/____/______

Utilization Management Department Phone: **CCC Plus**: 1-800-424-4524 or **Medallion 4.0**: 1-800-424-4518
UM CCC Plus Fax: 1-866-210-1523 or **UM Medallion 4.0 Fax**: 1-855-769-2116

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