MOLINA HEALTHCARE | Molina Complete Care

Molina Behavioral Health Psychiatric Inpatient Initial Authorization Form

Member information	
Member name:	Member ID/Policy #
Member DOB:	Date of admission:
TDO/ECO: ☐ Yes ☐ No	Hearing date:

Facility information	
Facility name:	Facility NPI:
Attending MD:	Attending MD NPI:
Is the facility in the MCC network? ☐ Yes ☐ No	If yes, please provide NPI:
Tax ID:	Provider UM contact:
UM phone:	UM fax:
Discharge planner's name:	Discharge planner's phone:

Psychiatric/substance use diagnosis with ICD-10 codes:			

Pertinent medical information
Patient's medical history and/or current medical issues or concerns:
Pertinent lab value(s) with dates:
Pertinent vital signs and CIWA/COWS scores with dates:

Please submit all relevant clinical information through the Availity portal or fax to the number below:
CCC Plus and Medallion 4.0: 1-855-339-8179 MCC of VA (HMO SNP): 1-888-656-2621

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Initial clinical presentation:		
Review date:		
Presenting problem:		
Precipitating events:		
Suicidal: ☐ Denies ☐ Reports ☐ Plan	Details:	
Homicidal: ☐ Denies ☐ Reports ☐ Plan	Details:	
Duty to warn reported: ☐ Yes ☐ No	If no, please explain:	
Self-Harm: ☐ Denies ☐ Gesture(s)	Details:	
Aggression: ☐ Denies ☐ Behaviors	Details:	
Psychosis symptoms: ☐ Delusions ☐ Paranoia Hallucinations: ☐ Denies ☐ Visual ☐ Auditory ☐ Tactile Details:		
Precautions: ☐ Suicide ☐ Elopement ☐ 1:1 ☐ Line of Sight	Date precautions Initiated:	Date precautions discontinued:

Physician notes
Physician clinical summary (Please include original copies of physician/provider notes):
Mental status exam:
Current psychiatric/neurologic medications and significant medical medications (include name, dose, date ordered, date changed, last time PRN meds given):

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Risk assessment:
Initial Treatment Plan:

Psychosocial information and discharge planning
Social history:
Outpatient mental health providers:
Initial Discharge Plan:
Additional information
Please include any other pertinent information to support the behavioral health psychiatric inpatient stay:

Form filled out by:	Date:

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