



**Molina Healthcare of Washington**  
**Medicaid Pediatric Long-Term Care**  
**Prior Authorization Request Form**  
Phone Number: (800) 869-7175  
Fax Number: (800) 767-7188

MEMBER INFORMATION					
Plan:	<input type="checkbox"/> Molina Medicaid (If Molina is secondary, please include a copy of the denial from primary insurance)				
Member Name:		DOB:	/ /		
Member ID#:		Phone:	( ) -		
REFERRAL/SERVICE TYPE REQUESTED					
Request Type:	<input type="checkbox"/> New Admission (HCPCS Code T1030 Pediatric Long-Term Care)				
	<input type="checkbox"/> Continued Stay Review – Authorization #				
<b>90 DOS SPAN ONLY</b> For continuation requests, the start date is always the day after the last authorization ends		DOS from: / / to / /			
PROVIDER INFORMATION					
Requesting Provider Name:		NPI#:		TIN#:	
Servicing Provider or Facility:		NPI#:		TIN#:	
Contact at Requesting Provider's Office:					
Phone Number:	( ) -	Fax Number:	( ) -		
CLINICAL DOCUMENTATION TO SUPPORT NEED FOR PEDIATRIC LONG-TERM CARE FACILITIES					
<b>Signed and dated physician order for 24-hour Skilled Nursing Care</b>		<input type="checkbox"/> Submitted			
<b>Current plan of care/physician's orders</b>		<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted		
<b>Week of recent nurse's notes</b>		<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted		
<b>Appointment notes/physician visit summaries</b>		<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted		
<b>Medical changes/discharge planning notes</b>		<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted		
<b>90 day summary/including changes</b>		<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted		