Molina Healthcare, Inc. Preservice Request Form

Home Health Care and Outpatient Therapy (Initial and Continuation)

MEMBER INFORMATION				
Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **MMP/Duals**	**Date of Request:**
State/Health Plan (IL):	Illinois			
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID:			**Member Phone**:	
Service Type:	☐ Prior Authorization: Non-Urgent/Routine/Elective ☐ Prior Authorization: Urgent/Expedited – Clinical Reason for Urgency **Required**:_____			

Request Type:	☐ **Initial Request**	☐ **Extension/Renewal/Amendment**	**Auth No.:**

Select only one (1); each modality requires a separate authorization request form.

Home Health Care

- For PAR (in-network) providers, initial evaluation plus six (6) visits per therapy type do not require PA.
- If an authorization number was already received for THIS diagnosis/episode of care **and** this request is a **continuation** request for additional sessions/visits, please indicate the authorization number here: _____. If not, please skip ahead.

Outpatient Therapy

- For PAR providers, initial evaluation plus 12 sessions per therapy type do not require PA.
- If an authorization number was already received for THIS modality and THIS diagnosis **and** this request is a **continuation** request for additional sessions/visits, please indicate the authorization number here: _____.

Modality	**Code**	**Diagnosis** One (or more) specific diagnosis codes that justify why the member requires THIS service; please avoid non-specific codes as primary diagnoses.	**Number of visits seeking authorization for this request**	**TOTAL number of visits member has completed for THIS calendar year for THIS episode of treatment/diagnosis and THIS therapy type**	**Has the member had an inpatient hospitalization in the last 30 days? If so, what are the admission and discharge dates?**	
					Admission	**Discharge**
☐ Skilled Nursing						
☐ Physical Therapy						
☐ Occupational Therapy						
☐ Speech Therapy						

PROVIDER INFORMATION

GROUP / FACILITY:

Name:		**NPI:**	**TIN:**	
Phone:	**Fax**:		**Email**:	
Address:		**City:**	**State:**	**ZIP:**
PCP Name:		**PCP Phone**:		
Office Contact Name:		**Office Contact Phone**:		

RENDERING / SERVICING PROVIDER:

Name:			
NPI:	**TIN:**	**Medicaid ID (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:	**Fax:**	**Email:**	
Address:	**City:**	**State:**	**ZIP:**

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.