# Molina Healthcare of Illinois, Inc. Medicaid
## Prior Authorization/Preservice Review Guide
## Effective: 01/01/2026

**Refer to Molina's Provider Website or Prior Authorization LookUp 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 REQUIRE NOTIFICATION, NOT PRIOR AUTHORIZATION.**

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol, and Chemical Dependency Services:**
  - Inpatient (requires notification and concurrent review), Substance Use Disorder—Residential Treatment
  - Targeted Case Management
  - Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for the treatment of Autism Spectrum Disorder (ASD)
- **Cardiology[1]:** Select services are administered by Evolent (NCH).
- **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**
- **Healthcare Administered Drugs**
- **Home Health Care Services (including home-based PT/OT/ST)** (Complete the Home Health/Therapy Form
- **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 requires 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** (Complete the Home Health/Therapy Form)
- **Oncology[1]:** Select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures[1]**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery[1]:** Select services are administered by Evolent.
- **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.**

**[1] Services provided by Evolent (NCH): Cardiology Authorizations for Adults applies to IL, KY, MI, NV, OH, WA. Oncology Authorizations for Adults applies to KY, IL, NV, WA.**

## IMPORTANT INFORMATION FOR MOLINA 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 are also 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 (855) 866-5462.

## IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

**Service hours 8 a.m. to 5 p.m. Central, Monday through Friday, unless otherwise specified.**

**Prior Authorizations, including Behavioral Health**
Availity Essentials Portal
provider.molinahealthcare.com

**Provider Services**
Phone: (855) 866-5462

**Pharmacy Authorizations**
Phone: (855) 866-5462
Fax: (855) 365-8112

**Member Services**
Phone: (855) 687-7861 or TTY 711

**Dental (SKYGEN)**
Phone: (262) 946-4400
Website: SKYGEN Dental Hub

**Vision (Avēsis)**
Phone: (866) 857-8124
Website: myavesis.com

**Non-Emergent Transportation (MTM)**
Phone: (844) 644-6354
Fax: (877) 406-0658

**Healthmap**
Chronic Kidney Care
Phone: (877) 546-7004

**ProgenyHealth**
Medically Complex Newborns and NICU
Phone: (888) 832-2006
Fax: (888) 817-3624

**Evolent/New Century Health (NCH)**
Cardiology and Oncology Authorizations for Adults
Phone: (888) 999-7713
Website: my.newcenturyhealth.com

**24-Hour Behavioral Health Crisis (24/7 year-round)**
Phone: (855) 687-7861 or TTY 711
English and Spanish
No referral or prior authorization is needed.

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

**National Suicide Lifeline (24/7 year-round)**
Phone: 988
No referral or prior authorization is needed.

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**Providers are strongly encouraged to utilize Molina Healthcare's portal:** provider.molinahealthcare.com

Among the many available features are:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Digital Correspondence Hub
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report
- Much More

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# Molina Healthcare, Inc.

## MEDICAL Preservice and Concurrent Review Request Form

### 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<br>☐ Prior Authorization: Urgent/Expedited – Clinical Reason for Urgency **Required**:_____<br>☐ Emergent Inpatient Admission – **Date of Admission**: _____ | | | |

### REFERRAL/SERVICE TYPE REQUESTED

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

| **Inpatient Services:** | **Outpatient Services:** | | ☐ Out-of-State Requests |
|---|---|---|---|
| ☐ Inpatient Hospital (Medical) | ☐ DME Enteral Formula/Supplies | ☐ Imaging/Special Tests | ☐ Transportation |
| ☐ Long-Term Acute Care (LTAC) | ☐ DME Wheelchair (purchase/repair) | ☐ Infusion Therapy/Home Infusion | ☐ Wound Care |
| ☐ Acute Inpatient Rehabilitation (AIR) | ☐ Diagnostic Procedure | ☐ Laboratory Services | ☐ Other: _____ |
| ☐ Skilled Nursing Facility (SNF) | ☐ Hospice | ☐ Office Procedures | |
| ☐ Ventilator Services | ☐ Hyperbaric Therapy | ☐ Outpatient Surgical/Procedure | |
| ☐ OB Notification ☐ Vaginal ☐ C-Section | | ☐ Prosthetic/Orthotic | |
| ☐ NICU | | | |

**CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION ARE REQUIRED TO REVIEW FOR MEDICAL NECESSITY (100 pages or less)**

**** HOME HEALTH/THERAPY: SUBMIT HOME HEALTH/THERAPY FORM ****

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

| Dates of Service Start | Stop | Procedure/ Service Codes | Diagnosis Code | Requested Service | Requested Units/Visits |
|---|---|---|---|---|---|
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### PROVIDER INFORMATION

#### GROUP/FACILITY:

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

#### RENDERING/SERVICING PROVIDER:

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **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. 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<br>☐ 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**: | | |
| | **Office Contact Fax:** | | |

#### RENDERING/SERVICING PROVIDER:

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **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.

## BEHAVIORAL HEALTH Preservice and Concurrent Review Request Form

### 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<br>☐ Prior Authorization: Urgent/Expedited – Clinical Reason for Urgency (**Required**):_____<br>☐ Emergent Inpatient Admission – **Date of Admission**: _____ | | | |

### REFERRAL/SERVICE TYPE REQUESTED

| | | | |
|---|---|---|---|
| **Request Type:** | ☐ **Initial Request** | ☐ **Extension/ Renewal / Concurrent** | **Auth No.:** |

| **Inpatient Services:** | **Outpatient Services:** | |
|---|---|---|
| ☐ Inpatient Psychiatric<br>☐ Involuntary ☐ Voluntary<br>☐ Inpatient Detoxification, BH Unit<br>☐ Residential Treatment (ASAM 3.5)<br>☐ Subacute Detoxification (ASAM 3.7) | ☐ Partial Hospitalization Program<br>☐ Intensive Outpatient Program<br>☐ Electroconvulsive Therapy<br>☐ Psychological/Neuropsychological Testing<br>☐ Applied Behavioral Analysis | ☐ Non-PAR Outpatient Services<br>☐ Other: _____ |

**CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION ARE REQUIRED TO REVIEW FOR MEDICAL NECESSITY (100 pages or less)**

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

| Dates of Service Start | Stop | Procedure/ Service Codes | Diagnosis Code | Requested Service | Requested Units/Visits |
|---|---|---|---|---|---|
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### PROVIDER INFORMATION

#### GROUP/FACILITY:

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

#### RENDERING/SERVICING PROVIDER:

| | | | |
|---|---|---|---|
| **Name:** | | | |
| **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.