SERVICE REQUEST FORM

INSTRUCTIONS

[Do not schedule non-emergency services requiring Prior Authorization until authorization is given]

[This form is to be completed by the REQUESTING provider/practitioner]

TRACKING NUMBER - Do not write in this space.

PRODUCT – Check the box to indicate which product the member belongs to.

SERVICE - Describe level of medical services needed. Please check one. Urgent or Non-Urgent. (**Emergency Services which meet Title 22 definition for an emergency do not require plan authorization.)**
Urgent requests MUST be reserved for services that are, in the provider's best professional judgment , potentially life threatening or pose a significant risk to the continuous care of the patient if not performed within 72 hours,. MHC reserves judgment of urgency and must meet definition above, therefore, please provide an explain of the reason for urgency on the form.

DATE - Enter the date in which the form was completed by the REQUESTING provider/ practitioner.

PATIENT INFORMATION - Complete all lines - Member Name, Date of Birth, Member ID (social security number or California Identification number, Address, Phone Number.

REFERRAL/SERVICE TYPE REQUESTED: - Check one or more boxes that best describe your request. Use "other" for unlisted services, and the "Comments" line to describe the service requested. (i.e., outpatient physician therapy, home IV therapy, non-formulary medication.)

REQUESTING" PROVIDER INFORMATION - Complete all lines including Requesting Provider Name, Specialty, Address, Telephone and Fax numbers.

REFERRING TO" PROVIDER INFORMATION - Complete all lines including Provider Name, Specialty, Address, Telephone and Fax numbers. (If referring to non-contracted provider, note the reason.)

SERVICE REQUEST INFORMATION - Accurate ICD-9, CPT and HCPC codes are REQUIRED. Include narrative description if needed.

CLINICAL INDICATIONS FOR REQUEST - Must be completed. Include pertinent medical history, test results, physical findings, all relevant medical records, information, necessary to explain the medical necessity of the requested service. Requests can not be processed if supporting clinical information is not provided to make a medical necessity determination.
Requesting Provider must sign and date where indicated.

Molina USE ONLY - Do not write in this space.

Upon completion of the utilization review / decision, the Service Request Form is returned to the REQUESTING PROVIDER/PRACTITIONER, distribute as indicated below:

- White - Molina UM Department
- Pink - Referring Provider
- Blue - Referred to Provider
- Yellow - Member

Note: Payment for these services by Molina is contingent on member's eligibility for Plan coverage on the date of service.