

Molina Healthcare of California

COMMUNITY BASED ADULT SERVICES (CBAS) REQUEST FOR SERVICES

*Please fax completed form to: **Molina Healthcare of California CBAS at 1-800-811-4804.** If you have any questions, you may call our Molina Utilization Management Department 1-800-526-8196.*

DATE:	PCP:	REFERRING PHYSICIAN:
PATIENT INFORMATION		
MEMBER NAME:	GENDER:	DOB:
	AGE:	MEMBER ID (Medi-Cal/CIN):
ADDRESS:	PHONE NUMBER:	ALTERNATE NUMBER:
PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) Enter Name and Address		Preferred Language:
REFERRAL - SERVICE TYPE REQUESTED		
<input type="checkbox"/> Expedited Referral for Post Hospitalization/SNF stay	<input type="checkbox"/> Initial CBAS Services <input type="checkbox"/> Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)	<input type="checkbox"/> Modification of Days for IPC
CBAS CENTER SUBMITTING THIS REQUEST		
PROVIDER NAME or Specify DBA:	PROVIDER NPI NUMBER:	PHONE NUMBER:
ADDRESS:	FAX NUMBER:	
DIAGNOSIS/PROCEDURE INFORMATION		
ICD-9 CODE(S) /DESCRIPTION:	CPT CODE(S)/DESCRIPTION:	HCPDS /DESCRIPTION:
MEDICAL JUSTIFICATION – Include pertinent information regarding IPC (i.e. past medical treatment, physical findings) and attach all relevant medical records, test results, etc.		
DATES AND SPECIFIC SERVICES REQUESTED	DAYS PER WEEK	QUANTITY/UNITS
REQUESTING PROVIDER (PRINT):	SIGNATURE:	DATE:
Criteria/Guidelines Met: <input type="checkbox"/> yes <input type="checkbox"/> no	Authorization Status: <input type="checkbox"/> approved <input type="checkbox"/> modified <input type="checkbox"/> deferred <input type="checkbox"/> denied	Authorization Number:
Comments:		

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THIS REFERRAL IS VALID FOR 30 DAYS ONLY