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

☐ **Expedited Referral for Post Hospitalization/SNF stay**	☐ **Initial CBAS Services** ☐ **Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)**	☐ **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:**	**HCPCS /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: ☐ yes ☐ no	**Authorization Status:** ☐ approved ☐ modified ☐ deferred ☐ denied	**Authorization Number:**

Comments:

THIS REFERRAL IS VALID FOR 30 DAYS ONLY