



**MOLINA® HEALTHCARE MEDICARE**  
**PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE**  
**EFFECTIVE: 04/01/2021**

**FOR DUAL MEMBERS WITH MEDICAID, PLEASE REFER TO YOUR STATE MEDICAID PA GUIDE FOR  
ADDITIONAL PA REQUIREMENTS**

**REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC  
CODES THAT REQUIRE AUTHORIZATION**  
**ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT**

**OFFICE VISITS TO CONTRACTED/PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA.**  
**OFFICE VISITS TO NETWORK SPECIALISTS DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER**  
**EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.**

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| <ul style="list-style-type: none"><li>• <b>Advanced Imaging and Specialty Tests</b></li><li>• <b>Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:</b><ul style="list-style-type: none"><li>○ Inpatient, Partial hospitalization;</li><li>○ Electroconvulsive Therapy (ECT).</li></ul></li><li>• <b>Chiropractic Care</b></li><li>• <b>Cosmetic, Plastic and Reconstructive Procedures:</b><br/>No PA required with Breast Cancer Diagnoses.</li><li>• <b>Durable Medical Equipment and Medical Supplies</b></li><li>• <b>Elective Inpatient Admissions:</b> Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.</li><li>• <b>Experimental/Investigational Procedures</b></li><li>• <b>Genetic Counseling and Testing</b></li><li>• <b>Healthcare Administered drugs</b><ul style="list-style-type: none"><li>○ For Medicare Part B drug provider administered drug therapies, please direct Prior Authorization requests to Novologix via the Molina Provider Portal. You may also fax in a prior authorization at 800-391-6437.</li></ul></li><li>• <b>Hearing Aides</b><ul style="list-style-type: none"><li>○ Benefit is only available from HearUSA participating providers. Hearing aids require prior authorization</li></ul></li><li>• <b>Home Healthcare Services (including home-based PT/OT/ST)</b></li><li>• <b>Hyperbaric/Wound Therapy</b></li><li>• <b>Long Term Services and Supports (LTSS):</b> Not a Medicare covered benefit*. (*Per State benefit if MMP)</li><li>• <b>Miscellaneous &amp; Unlisted Codes:</b> Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.</li></ul> | <ul style="list-style-type: none"><li>• <b>Neuropsychological and Psychological Testing</b></li><li>• <b>Non-Par Providers/Facilities:</b> PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:<ul style="list-style-type: none"><li>○ Emergency and Urgently needed Services;</li><li>○ Professional fees associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;</li><li>○ Dialysis when temporarily absent from service area.</li><li>○ Ambulance services dispatched through 911</li><li>○ PA is waived for all radiologists, anesthesiologists, and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24</li><li>○ PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.</li></ul></li><li>• <b>Occupational, Physical, &amp; Speech Therapy:</b> PA required after Medicare therapy benefit threshold (\$2,110 for PT &amp; ST combined and \$2,110 for OT) has been reached for office and outpatient settings.</li><li>• <b>Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures</b></li><li>• <b>Pain Management Procedures including acupuncture</b></li><li>• <b>Prosthetics/Orthotics</b></li><li>• <b>Radiation Therapy and Radiosurgery</b></li><li>• <b>Sleep Studies</b></li><li>• <b>Supervised Exercise Therapy (SET)</b></li><li>• <b>Transplants including Solid Organ and Bone Marrow</b> (Cornea transplant does not require authorization).</li><li>• <b>Transportation Services:</b> non-emergent air transportation.</li></ul> |
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## IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICARE 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 also are 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.

### IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION

#### CALIFORNIA (Service Hours: 8am to 5pm local time Monday to Friday, unless otherwise specified)

<b>In-patient (IP) Prior Authorizations</b> Phone: (800) 526-8196 Fax: (866) 472-6303	<b>Pharmacy Authorizations:</b> Phone: (800) 665-3086 Fax: (866) 290-1309
<b>Out-patient (OP) Prior Authorizations:</b> Phone: (855) 322-4075 Medicare Fax: (844) 251-1450 MMP Fax: (844) 251-1451	<b>Provider Customer Service:</b> Phone: (855) 322-4075 Fax: (562) 951-1529
<b>Behavioral Health Authorizations:</b> Phone: (800) 665-0898 Fax: (866) 472-6303	<b>Dental (Delta Dental):</b> Phone: (855) 818-7932 TTY: 711 Website: <a href="https://www.deltadental.com">https://www.deltadental.com</a>
<b>Radiology Authorizations:</b> Phone: (855) 714-2415 Fax: (877) 731-7218	<b>Hearing (HearUSA):</b> Phone: (800) 442-8231 Website: <a href="https://www.hearusa.com/">https://www.hearusa.com/</a>
<b>Transplant Authorizations:</b> Phone: (855) 714-2415 Fax: (877) 813-1206	<b>Vision (March Vision Care):</b> Phone: (844) 336-2724, TTY: 711 or (877) 627-2456 Website: <a href="https://www.marchvisioncare.com">https://www.marchvisioncare.com</a>
<b>Member Customer Service, Benefits/Eligibility:</b> Phone: (800) 665-0898 TTY: 711	<b>Meals (Mom's Meals NourishCare PurFoods, LLC dba):</b> Phone: (866) 224-9485 – Case Managers
<b>Nurse Advice Line: (7 days/week)</b> <i>No referral or prior authorization is needed.</i> Phone: (888) 275-8750 (TTY: 711) Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.	<b>Transportation</b> Phone: (888) 276-4781 TTY: 711 or (866) 874-3972 Facility Line: (877) 299-4811
<b>Providers may utilize Molina Healthcare's Website at: <a href="https://provider.molinahealthcare.com/Provider/Login">https://provider.molinahealthcare.com/Provider/Login</a></b> Available features include: <ul style="list-style-type: none"> <li>• <b>Authorization submission and status</b></li> <li>• <b>Member Eligibility</b></li> <li>• <b>Provider Directory</b></li> <li>• <b>Claims submission and status</b></li> <li>• <b>Download Frequently used forms</b></li> <li>• <b>Nurse Advice Line Report</b></li> </ul>	

## Molina® Healthcare, Inc. – Prior Authorization Request Form

### MEMBER INFORMATION

<b>Line of Business:</b>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	<b>Date of Request:</b>
<b>State/Health Plan (i.e. CA):</b>				
<b>Member Name:</b>				<b>DOB (MM/DD/YYYY):</b>
<b>Member ID#:</b>				<b>Member Phone:</b>
<b>Service Type:</b>	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency <b>Required:</b> _____ <input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> EPSDT/Special Services			

### REFERRAL/SERVICE TYPE REQUESTED

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth#:</b>
<b>Inpatient Services:</b>		<b>Outpatient Services:</b>	
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____		<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Chiropractic  <input type="checkbox"/> Dialysis  <input type="checkbox"/> DME  <input type="checkbox"/> Genetic Testing  <input type="checkbox"/> Home Health  <input type="checkbox"/> Hospice  <input type="checkbox"/> Hyperbaric Therapy  <input type="checkbox"/> Imaging/Special Tests         </div> <div style="width: 50%;"> <input type="checkbox"/> Office Procedures  <input type="checkbox"/> Infusion Therapy  <input type="checkbox"/> Laboratory Services  <input type="checkbox"/> LTSS Services  <input type="checkbox"/> Occupational Therapy  <input type="checkbox"/> Outpatient Surgical/Procedures  <input type="checkbox"/> Pain Management  <input type="checkbox"/> Palliative Care         </div> <div style="width: 50%;"> <input type="checkbox"/> Pharmacy  <input type="checkbox"/> Physical Therapy  <input type="checkbox"/> Radiation Therapy  <input type="checkbox"/> Speech Therapy  <input type="checkbox"/> Transplant/Gene Therapy  <input type="checkbox"/> Transportation  <input type="checkbox"/> Wound Care  <input type="checkbox"/> Other: _____         </div> </div>	

### PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

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

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

### PROVIDER INFORMATION

#### REQUESTING PROVIDER / FACILITY:

<b>Provider Name:</b>	<b>NPI#:</b>	<b>TIN#:</b>
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>
<b>Address:</b>	<b>City:</b>	<b>State:</b> <b>Zip:</b>
<b>PCP Name:</b>		<b>PCP Phone:</b>
<b>Office Contact Name:</b>		<b>Office Contact Phone:</b>

#### SERVICING PROVIDER / FACILITY:

<b>Provider/Facility Name (Required):</b>			
<b>NPI#:</b>	<b>TIN#:</b>	<b>Medicaid ID# (If Non-Par):</b>	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
<b>Phone:</b>	<b>FAX:</b>	<b>Email:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

#### For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.

# Molina® Healthcare, Inc. – BH Prior Authorization Request Form

## MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

## REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  If Involuntary, Court Date: _____	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management  <input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____		

## PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment:

Description:

DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

## PROVIDER INFORMATION

### REQUESTING PROVIDER / FACILITY:

Provider Name:	NPI#:	TIN#:
Phone:	FAX:	Email:
Address:	City:	State: Zip:
PCP Name:	PCP Phone:	
Office Contact Name:	Office Contact Phone:	

### SERVICING PROVIDER / FACILITY:

Provider/Facility Name (Required):			
NPI#:	TIN#:	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Phone:	FAX:	Email:	
Address:	City:	State:	Zip:

### For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.