

Molina® Healthcare, Inc. – BH Prior Authorization Request Form Providers may utilize Molina's Provider Portal:

- **Claims Submission and Status**
- **Authorization Submission and Status**
- **Member Eligibility**

Duals Dual		MEMBER INFORMATION								
State-Health Plan (i.e. CA) Member 10H:	Line of	☐ Duals					AE (Medicaid)	Date of Request:		
(i.e. CA):						<u> </u>		•		
Member Name: DOB (MM/DD/YYYY) Member Phone:										
Service Type: Onther (Please Specify): Ont	, ,					DOB (MM/DD/YYYY)				
Cher (Please Specify):	Member ID#	:					Member Phon	1e:		
Inpatient ER Admission (Concurrent) PFSDT/Specials Services Cal PA request. Medicare Denial, requires Medicaid Review	Service Type	□ Non-Urgent/Ro	utine/Elective		Т 🗆 Т			ive		
CA IPA request. Medicare Denial, requires Medicaid Review REFERRAL/SERVICE TYPE REQUESTED					(Ratio			ationale):		
CA PA request: Medicare Denial, requires Medicaid Review REFERRAL/SERVICE TYPE REQUESTED		☐ Inpatient ER Ad	☐ Inpatient ER Admission (Concurrent)							
REFERRAL/SERVICE TYPE REQUESTED Date of Request:		•				ļ				
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Business: Duals	REFERRAL/SERVICE TYPE REQUESTED									
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Member ID#: Service Type: Other (Please Specify): Inpatient ER Admission (Concurrent)	(i.e. CA)	:								
Service Type: Other (Please Specify): Inpatient ER Admission (Concurrent)	Member Name	:	DOB (MM/DD/YYYY)							
Other (Please Specify):	Member ID#	:					Member P	hone:		
Inpatient ER Admission (Concurrent) REFERRAL/SERVICE TYPE REQUESTED	Service Type	J								
Request Type: Initial Request Extension/Renewal/Amendment Previous Auth #										
Request Type: Initial Request Extension/Renewal/Amendment Previous Auth # Inpatient Services: Outpatient Services: Check Residential Treatment Check	·									
Inpatient Services:			1	FERRAL/SERVICE TYPE REQUESTED						
Inpatient Psychiatric			□ Extension/Renewal/Amendment □ Previous Auth #							
Involuntary			•							
Intensive Outpatient Program			1							
Inpatient Detoxification	∐Involuntary	∐Voluntary	_							
Involuntary	□Innatient Detoxi	fication	-				1			
Targeted Case Management	=									
PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION		_ · · · · · · · · · · · · · · · · · · ·		, and the second				· ·		
PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION Primary ICD-10 Code for Treatment: DATES OF SERVICE Start Stop PROVIDER INFORMATION Requesting/Referring Provider/Facility: Provider Name: Phone: Fax: Address: City: PCP Name: Office Contact Name: Office Contact Name: Servicing/Billing Provider/Facility: Provider/Facility: PCP Name: Office Contact Name: Servicing/Billing Provider/Facility: Provider/Facility Name (Required): NPI# TIN# Medicaid ID# (If Non-Par): Semail: Address: City: State: Zip: PCP Phone: Servicing/Billing Provider/Facility: Provider/Facility Name (Required): NPI# TIN# Medicaid ID# (If Non-Par): Semail: Address: City: State: Zip:	If Involuntary Court Date:		Li laigeleu Caso	Litargeted Case Management						
Primary ICD-10 Code for Treatment: Description: Dates Of Service Start Stop Procedure/Services Diagnosis Requested Service Requested Service Units/Visits										
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					State:					
	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. Medicare PA Request Form Effective: 1/1/2024