

Plan:

Molina Medicaid

Molina Healthcare of Michigan Medicaid, MIChild and Medicare Prior Authorization Request Form

Phone: (888) 898-7969

Medicaid Fax: (800) 594-7404 / Medicare Fax: (888) 295-7665

Radiology, NICU, and Transplant Authorizations: Phone: (855) 714-2415 / Fax: (877) 731-7218

MEMBER INFORMATION

Molina Medicare

MIChild

DOB:

Other:

Member ID#:	Member Name:				DOB:	/	/				
*Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent. Referral/Service Type Requested	Member ID#:				Phone:	())	-			
requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent. Referral/Service Type Requested	Service Type:			☐ Expedited/Urgent*							
Impatient Surgical Procedure Surgical Procedure Surgical Procedure Surgical Procedure Surgical Procedure Surgical Procedure SNF Rehab LTAC Diagnosis Code & Description: CPT/HCPC Code & Description: Number of visits requested: PROVIDER INFORMATION Requesting Provider Name: Facility Providing Service: Rendering Facility Address: Contact at Requesting Provider's office: Phone Number: () - Fax Number: () - For Molina Use Only:	requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this										
Surgical procedure Surgical Procedure Diagnostic Procedure Number of visits requested: Provider Name: Facility Providing Service: Rendering Facility Tax ID #: Rendering Facility Address: Contact at Requesting Provider's office: Phone Number: Surgical Procedure Diagnostic Procedure Number of Visits requested: DOS From: DOS											
ER Admits					T. OT. & ST)			Home H	lealth		
Diagnosis Code & Description: CPT/HCPC Code & Description: Number of visits requested: DOS From: / / to / / Please send clinical notes and any supporting documentation PROVIDER INFORMATION Requesting Provider Name: Facility Providing Service: Rendering Facility Tax ID #: Rendering Facility Address: Contact at Requesting Provider's office: Phone Number: () - Fax Number: () - For Molina Use Only:	☐ER Admits ☐Dia		gnostic Pro	_	Chiropractic				DME		
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For Molina Use Only:	Contact at Requesting	s office:									
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