TITLE XIX REQUEST for PRIOR APPROVAL INPATIENT REHABILITATION SERVICES

MAIL TO:
Molina Healthcare of NM TPA
PO Box 3909
Albuquerque, NM 87190

Patient's Name - Last First MI	MEDICAID ID Number	Date of Birth	Sex ☐ M ☐ F

Diagnosis:	Name/Address/Zip Code of Facility to which Admission is Requested

PROVIDER NUMBER	NPI Number	Taxonomy Number	Date Onset of Disability if known

Has this patient been treated at this facility before? ☐ Yes ☐ No	Name of Referring Physician

ASSESSMENT of PATIENT'S DISABILITIES

DESCRIPTION of COMPREHENSIVE REHABILITATION PLAN

GOALS of THERAPY

Number of Days of Inpatient Rehabilitation Request? ________	☐ Request for Evaluation **ONLY**	Physician Signature
☐ Approved for ________ Days PA Number ____________	Beginning Date ____________ Ending Date ____________	☐ Request Denied PA Number ____________

MAD 331 Form Revised 9/24/09

Cc:
UR Agent
Fiscal Agent
Provider File