



**Molina® Healthcare – Medicaid/Essential Plan
Prior Authorization Request Form
Utilization Management
Phone: 1-877-872-4716
Fax: 1-866-879-4742**

MEMBER INFORMATION

Plan: Molina® Medicaid Other:

Member Name: _____ **DOB:** / /

Member ID#: _____ **Phone:** () -

Service Type: Elective/Routine Expedited/Urgent¹

¹**Definition of Expedited/Urgent 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

Inpatient

- Surgical procedures
- Admissions
- SNF
- LTAC

Outpatient

- Surgical Procedure
- Diagnostic Procedure
- Infusion Therapy
- Other: _____
- Hyperbaric Therapy
- Pain Management
- DME

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 _____ NPI# _____ TIN# _____

Servicing Provider or Facility: _____ NPI# _____ TIN# _____

Contact at Requesting Provider’s Office*: _____

*Phone Number: () - *Fax Number: () -

Non-Participating/Non-Network Provider Name: _____ Group Name: _____

Provider Address: _____ Group Tax ID: _____

City, State, Zip: _____ Medicaid ID (If Individual Provider): _____

Phone: _____ Fax: _____ Provider NPI: _____

Group NPI: _____

***For non-participating/non-network providers who do not complete this form, the form will be returned and may delay the determination for requested services.**

For Molina® Use Only:

Revised June, 2018