

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 <input type="checkbox"/> EPSDT/Special Services			

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 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: _____		<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic/Genomic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests <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 <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: _____	

J Code Drug Requests (Include J Code, Drug Name, Dosage, and Frequency)

J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	
J Code:		Drug Name:		Dosage:		Frequency:	

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:					
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, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.