OBSTETRICAL Service Request Form

IN NETWORK NOTIFICATION/OUT OF NETWORK AUTHORIZATION
Fax completed document to: 1-866-420-3639
e-Portal: www.molinahealthcare.com

Reference#: _____ **Start Date:** _____ **End Date:**_____
(Include on claim)

This reference number is not a guarantee of reimbursement or of the member's medical expenses. Reimbursement is based on eligibility, medical necessity and the benefit provisions of the member's plan at the time services were rendered.

FOR MOLINA USE ONLY	**AUTHORIZATION STATUS:**	☐ **Approved**	☐ **Denied**	☐ **Modified**	☐ **Deferred**

Information Submitted To Molina By: _____ Phone Number:_____

Member Information

Member Name (Last, First, MI)	Date of Birth / /	Member I.D.
Address: (No., Street, City, State, Zip)		Phone Number: ( )
Minor Child: ☐ Y ☐N	Parent/Guardian Name (Required for Minors):	

Procedure/Service Information (codes required)

*Please attach pertinent clinical information, progress notes, and/or diagnostic tests

Service Requested: ☐ **Total OB Care(includes 2 ultrasounds)** ☐ **Prenatal Visit** ☐ **Labor/Delivery** ☐ **Post-partum Visit**
☐ **Sterilization(requires consent form signed 30 days prior)**

ICD-9 Code # **&** Description: **(REQUIRED)**	CPT Code # **&** Description: **(REQUIRED)**	HCPC # & Description: **(REQUIRED for EACH Item)**
LMP: EDD: Date of First Prenatal Visit:	Gravida: Para: Ab: Height: Weight:	Multiple Gestation ☐ YES ☐ NO(#)___ High risk ☐ YES ☐ NO

Is the patient/member diagnosed with or have a history of the following?

☐ **Gestational Diabetes** ☐ **bleeding after 12 weeks** ☐ **Pregnancy Induced Hypertension** ☐ **Smoking**

☐ **Pre- Term Labor** ☐ **Hyperemesis** ☐ **Pyleonephritis** ☐ **Cerclage** ☐ **Placenta previa**

☐ **Other (please explain)**_____ **Maternal Age:** ☐ **>35 years** ☐**14-17 years**

Provider Information

Requesting Provider/Facility Name:	In Network: ☐ YES ☐ NO	Phone Number:
Address: (No., Street, City, State, Zip)		Fax Number:
REQUESTING PRACTITIONER SIGNATURE/AUTHORIZED PERSONNEL:		Date

WARNING: Health care information is personal and sensitive information related to a person's health and healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require direct patient authorization. You, the recipient, are obligated to treat this document as PHI and maintain it in a safe, secure and confidential manner. Re-disclosure or unauthorized disclosure is prohibited by law and failure to protect the confidentiality of the PHI could subject to statutory penalties under state or federal law.

Important Message to the Recipient: If you are not the intended recipient of this confidential and privileged health care information, please notify the sender named at the top of this fax immediately. Disclosure or dissemination of this Personal Health Information is strictly prohibited by law.

Confirmed receipt_____Date_____Time_____