Notification of Authorized Services

To:

Company/Department:

Phone No./Extension:

Fax No:

From:

Department: **Molina Healthcare of Texas**

Phone No./Extension: **1-866-409-0039**

Fax Number: **1-866-420-3639**

Date:

Member Information		
Member Name (Last, First):	Date of Birth:	Medicaid #:
Address:		Phone Number:
Units per week 12rs:	Days per week:	Modifier:
Diagnoses:		**Auth Period:**
Tasks: [ ]Bathing [ ]Dressing [ ]Exercise [ ]Feeding [ ]Grooming [ ]Hair/Skin Care [ ]Toileting [ ]Transfer/Ambulation [ ]Cleaning [ ] Laundry [ ]Meal Prep [ ]Escort [ ] Shopping [ ]Med Reminder		
Comments		**Authorization Number ***

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