

MEMBER INFORMATION			
<b>Plan:</b>	<input type="checkbox"/> Molina Medicaid	<input type="checkbox"/> Molina Medicare	<input type="checkbox"/> Other
<b>Member Name:</b>			<b>DOB:</b> /        /
<b>Member ID#:</b>			<b>Phone:</b> (        )        -
<b>Service Type:</b>	<input type="checkbox"/> Elective/Routine (14-day turnaround time)		<input type="checkbox"/> Expedited/Urgent* (72-hr. turnaround time)

**\*Definition of Urgent / Expedited 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.**

\*Required Information to Process Request:

*REFERRAL/SERVICE TYPE REQUESTED			
<b>Inpatient</b> <input type="checkbox"/> Surgical procedures <input type="checkbox"/> ER Admits <input type="checkbox"/> SNF <input type="checkbox"/> LTAC	<b>Outpatient</b> <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Diagnostic Procedure <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Other:	<input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> Hyperbaric Therapy	<input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> In Office <input type="checkbox"/> Change Level of Care
<b>*Diagnosis Code &amp; Description:</b>			
<b>*CPT/HCPC Code &amp; Description:</b>			
<b>*Number of visits requested:</b>		<b>*DOS:</b>	From        /        /        to        /        /
<b>Level of Care (LOC)</b>	<input type="checkbox"/> ICU <input type="checkbox"/> Tele <input type="checkbox"/> Medical		

### Clinical Notes and Supporting Documentation is Required to Review for Medical Necessity

*PROVIDER INFORMATION			
<b>*Rendering Provider Name:</b>			<b>NPI:</b>
<b>*Facility Providing Service:</b>			<b>NPI:</b>
<b>*Contact at Requesting Provider's office:</b>			
<b>*Phone Number:</b>	(        )        -	<b>Fax Number:</b>	(        )        -
<b>For Molina Use Only:</b>			

This is confirmation of medical necessity only. This is not an approval for claim payment. Claims will be reviewed for correct coding and edits may be applied. This authorization is subject to (1) the member's benefit plan limitations, exclusions and conditions, (2) Molina's determination of the member's eligibility on the date that services are rendered, and (3) for participating providers, the terms of your contract with Molina Healthcare.