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/Urgent[1]

[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:

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