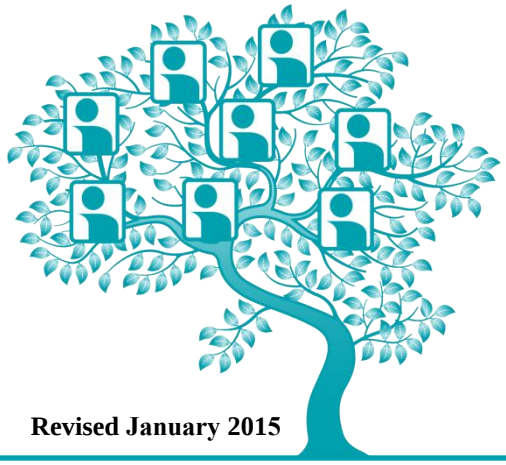
MOLINA® MEDICAL

2015

New Provider Orientation

California



Revised January 2015

New Provider Orientation & Acknowledgement

Molina Medical Group | California

This is to confirm that the undersigned Primary Care Physician (PCP) has received a Molina Medical Group (MMG) New Provider Orientation. The PCP understands the following components of the Provider/ Practitioner Manual, which contains important contact information and describes MMG's policies and procedures for Medi-Cal, Medicare, and exchange product line managed care programs.

- ❑ 1. MMG Story
- ❑ 2. MMG Directory
- ❑ 3. Physician Incentives
- ❑ 4. Initial Health Assessment
  - Staying Healthy Assessment
- ❑ 5. Utilization Management
  - UM Guidelines
  - UM Service Request Forms
- ❑ 6. Rosters
  - Contracted Hospital Roster*
  - Contracted Specialist Roster**
- ❑ 7. Claims and Encounter Data
  - Claims Guidelines
  - Provider Dispute Resolution Form
  - Encounter Data Submission
- ❑ 8. Language Assistance

_____

(PCP Name)

_____

(Specialty)

_____ _____ ____/____/____

(PCP Representative Print) **(PCP Representative Signature)** **(Date)**

_____ _____

_____ _____

(Site Address 1) **(Site Address 2)**

Active Contract Date: _____

MMG Provider Representative: _____

* As of September 2014
** As of October 27, 2014

Revised October 2014

STAYING HEALTHY ASSESSMENT (SHA)
TRAINING ATTESTATION & SIGN-IN FORM

Section I: Instructions

- ✓ It is mandatory that ALL Medi-Cal Managed Care Primary Care Providers (PCP) be trained on the implementation of the new Staying Healthy Assessment (SHA) forms. All PCPs are required to implement the SHA form during Initial Health Assessment (IHA) and periodic physical exams effective immediately.
- ✓ Follow the link to access the Provider PowerPoint ™ Training Presentation- http://tiny.cc/b1a29w Click on the Slide Show option if the audio portion of the training does not start. You can also access the training on Molina Medical Group website: molinaclinics.com/contracted-providers
- ✓ **Fax the completed form to Molina Provider Services at :**
  ■ LA County: (562) 499-6171 ■ Riverside/ San Bernardino County: (909) 623-5917 ■ Sacramento: (916) 561-6040
- ✓ For more information on the Staying Healthy Assessment, including SHA forms in all threshold languages and DHCS Policy Letter, please visit: www.dhcs.ca.gov
- ✓ If your clinic is planning to scan the paper-based SHA into your EMR or planning to use an electronic version of the SHA, please complete and fax the ELECTRONIC SHA NOTIFICATION FORM along with this training attestation. Electronic SHA notification form can be found on Molina Medical Group website: molinaclinics.com/contracted-providers

Section II: Provider Information

PROVIDER NAME		BUSINESS NAME (If applicable)	
STREET ADDRESS	CITY	STATE **CA**	ZIP CODE
COUNTY	TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

Section III: Attestation

I acknowledge that this office has received the updated Staying Healthy Assessment training via
☐ *Recorder Webinar* ☐ *On-site training* ☐ *Other:*

Signature of Physician/ Designee **X**	Printed Name and Date	Date

Section IV: Staying Health Assessment Training Agenda

- SHA Requirements
- Instructions on how to use the SHA
- Documentation requirements
- Timeliness for administration and review
- Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions
- Plan specific information regarding SHA resources and referral

Section V: All PCPs and Office Staff Sign-In Sheet (Please attach additional pages if necessary)

Printed Name and Title	Signature

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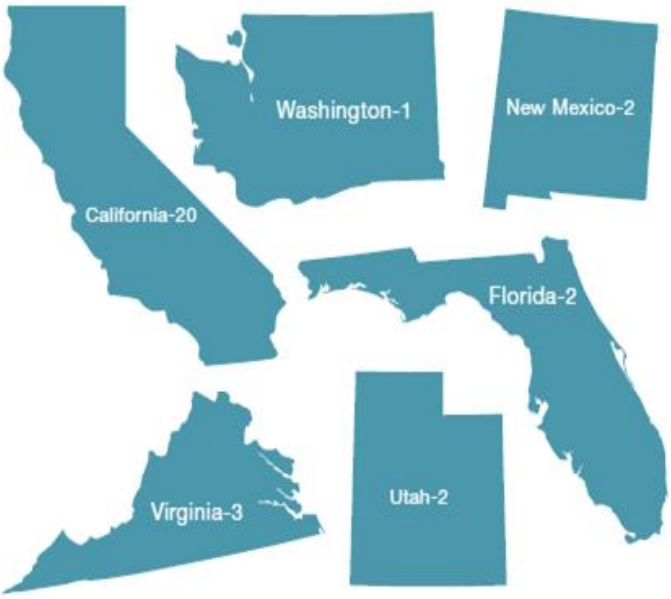
Molina Medical Group

About Molina Medical Group

Molina began with a single medical clinic in 1980, and while it continues to expand in this and other areas, the central motivation that spawned that first clinic remains- providing quality healthcare to under-served people. Molina Medical Group (MMG) is the forefront in providing direct care for patients.

MMG manages direct delivery of healthcare services to persons eligible for Medicaid, Medicare, and other government-sponsored programs for low-income families and individuals.

Today, MMG is working to expand its Provider network in Southern California to be able to provide more coverage to MMG members.



Mission Statement

Molina Healthcare's mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

Facts about Molina Medical Group

- Dr. C. David Molina opened his first clinic in Wilmington in 1980.
- MMG currently operates in six states (UT, CA, NM, WA, VA and FL) and has 30 clinics providing care to approximately 85,000 members.
- Primary Goal of the individual clinics is to provide quality preventive an ongoing care to individuals and families in areas where gaining access to quality care is difficult.

MOLINA® MEDICAL

Provider Quick Reference Guide | IMPORTANT NUMBERS

Main Phone: (562) 499-6191 ■ Toll Free: (888) 665-4621 ■ TTY: (800) 479-3310
Business Hours: 7:30am- 5:30pm Monday- Friday

Department	Contact Information	
Behavioral Health Services	(888) 562-5442, Ext 129558	
Bridge2Access℠ Program	(877) 665-4627	
Claims **EDI Vendor: Emdeon** **Emdeon Payer ID: 38333**	(855) 322-4075 **Select option for:** Option 1 [Medi-Cal] Option 2 [Marketplace] Option 3 [Medicare] Option 4 [Dual Options] **Then select option 3 for Claims**	Attn: Claims Department P.O. Box 22693 **[or 22702]** Long Beach, CA 90801
Community Outreach	(562) 435-3666, Ext 127227	
Cultural & Linguistic Specialist	(888) 665-4621, Ext 111032	
Encounter Data Submission	N/A	P.O. Box 22693 Long Beach, CA 90801
Fraud, Waste, Abuse Tip Line	(866) 606-3889	
Health Education	Contact your Regional Provider Services Representative	
Hearing Services (AVESIS – 3rd party administrator for hearing eligibility, claims & benefits)	(800) 327-4462	
Interpreter	(888) 665-4621	
Medicare Transportation Services	(866) 475- 5423	(866) 288-3133 (TTY)
Member Eligibility & Services	(800) 675-6110 [Medi-Cal] (855) 322-4075 [Marketplace] (800) 665-0898 [Medicare] (855) 655-4627 [Dual Options]	
Motherhood Matter Pregnancy Program	(866) 891-2320	
Pharmacy (CVS Caremark)	(888) 665-4621	(866) 508-6445 (Fax)
Provider Disputes	(888) 322-4075	P.O. Box 22722 Long Beach, CA 90801
Quality Improvement	(800) 526-8196, Ext 126137	
Utilization Management	(888) 562-5442, Ext 129558	Fax: (844) 710-1604
Vision Services	(888) 493-4070	www.marchvisioncare.com
Web Portal Help Desk	(866) 449-6848	
24 Hour Nurse Advice Hotline	(888) 275-8750	

PROVIDER SERVICES TEAM

Elizabeth Tejada **Vice President, MSO Operations**	**(562) 435-3666** **Ext. 121930**

California Region	Representative	Extension
Los Angeles **200 Oceangate, Suite 100** **Long Beach, CA 90802** **Phone: (562) 435-3666** **Fax: (562) 499-6171**	Jackie Pham *Director of Contracting & Provider Services*	Ext. 121212
	Helen Nguyen *Provider Services Representative II*	Ext. 129880
Riverside/ San Bernardino **887 E. 2ND Street, Suite B** **Pomona, CA 91766** **Phone: (888) 562-5442** **Fax: (909) 623-5917**	Mesrak Gessesse Director of Contracting & Provider Services	Ext. 121208
	Mary Margaret Castañeda *Provider Contracts & Services Manager*	Ext. 127224
	Maria Calderon *Provider Services Representative* *Riverside County*	Ext. 122218
	Alexis Martinez *Provider Services Representative* *San Bernardino County*	Ext. 122024
Sacramento **2180 Harvard Street, Suite 500** **Sacramento, CA 95815** **Phone: (888) 562-5442** **Fax: (916) 561-6040**	Steve Soto *Director of Contracting & Provider Services*	Ext. 128546
	Linda Baez *Provider Contracts & Services Manager*	Ext. 128543
	Aide Silva *Provider Services Representative*	Ext. 127140
	Juan Carlos Garcia *Provider Services Representative*	Ext. 126232

PHYSICIAN INCENTIVES

Did you know Molina pays you directly for the following services?

The following **services will be paid to the submitting physician** when billed appropriately and submitted within the required timeframe.

***90 Day Initial Health Assessments**

$30.00 fee paid when assessment is completed within 90 days of member's effective date with Molina.

- (99385) - 21 to 39 years
- (99386) - 40 to 64 years
- (99387) - 65 years and over

***USE ICD-9 CODE V70.0 TO INDICATE INITIAL HEALTH ASSESSMENT PHYSICAL EXAMINATION ON THE CMS 1500- SECTION 21.**

Immunizations

$5.00 fee paid for adult immunizations.

- (90471) - Immunization administration; single or combination vaccine/ toxoids
- (90472) – Immunization administration; two or more single or combination vaccines/toxoids

Mail CMS 1500 Forms to:

Molina Healthcare
PO Box 22702
Long Beach, CA 90801

Staying Healthy Assessment

The Staying Healthy Assessment (SHA) is a Department of Health Care Services requirement consisting of questionnaires for all Medi-Cal beneficiaries as part of their Initial Health Assessment (IHA). This assessment is designed to initiate dialogue between the member and Primary Care Provider (PCP) facilitating focused health education counseling addressing health behavior change. All providers of managed Medi-Cal members are required to use and administer the SHA for both new and existing patients.

SHA Periodicity Table

QUESTIONNAIRE	ADMINISTER	ADMINISTER/RE-ADMINISTER		REVIEW
Age Groups	**Within 120 Days of Enrollment**	**1st Scheduled Exam *(after entering new age group)***	**Every 3-5 Years**	**Annually *(intervening years)***
0 – 6 Months	✓	✓		
7 – 12 Months	✓	✓		
1 – 2 Years	✓	✓		✓
3 – 4 Years	✓	✓		✓
5 – 8 Years	✓	✓		✓
9 – 11 Years	✓	✓		✓
12 – 17 Years	✓	✓		✓
Adults	✓		✓	✓
Seniors	✓		✓	✓

- Annual re-administration is highly recommended for adolescents (12 – 17 Years) and Seniors due to frequently changing behavioral risk factors for this age group.
- PCP should select the assessment (Adult or Senior) best suited for the member's health and medical status, e.g., biological age, existing chronic conditions, mobility limitations

SHA Completion by Member

Self-completion is the preferred method of administering the SHA because it increases the likelihood of obtaining accurate responses to sensitive or embarrassing questions. Assure the member that SHA responses will be kept confidential in patient's medical record and that the member has the right to skip any question. The SHA's purpose and how it will be used by the Primary Care Provider (PCP) should be explained to the member.

- A parent/guardian must complete the SHA for children under twelve (12) years of age
- If preferred by the member or PCP, the PCP or other clinic staff may verbally ask questions and record the responses on the questionnaire

Should a member refuse to complete the SHA, the refusal must be documented, dated, and signed by the PCP. Members who previously refused/declined to complete the SHA should be encouraged to complete an age-appropriate SHA questionnaire each subsequent year during scheduled exams.

STAYING HEALTHY ASSESSMENT

PCP Responsibilities to Provide Assistance and Follow-up

- PCP must review and discuss newly completed SHA with patient. Other clinic staff may assist if under supervision of the PCP, and if the medical issues are referred to the PCP.
- If responses indicate risk factor(s), the PCP should prioritize member's health education needs and willingness to make lifestyle changes, provide tailored health education counseling, interventions, referral and follow-up.
- Annually, PCP must review and discuss previously completed SHA with patient (intervening years) and provide appropriate counseling and follow-up on patient's risk reduction plans, as needed.

Required PCP Documentation

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with member and assistance/follow-up was provided, as needed.
- PCP must check appropriate boxes in "Clinical Use Only" section to indicate topics and type of assistance provided to member.
- For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section to verify the annual review was conducted and discussed with the patient.
- Signed SHA must be kept in patient's medical record. Molina Healthcare Quality Improvement audits will check member's medical record for completed assessment and appropriate provider notations.

Obtaining SHA Forms

Should you need more SHA forms, please refer to the Department of Health Care Services (DHCS) website: http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

For assistance on navigating the DHCS website to obtain SHA forms, please follow the instructions below:

1. Go to: www.dhcs.ca.gov
2. Click on the "**FORMS, LAWS & PUBLICATIONS**" option on the top toolbar
3. Click on the first option, "**Forms**"
4. Under "All Forms," click on "**By Program**"
5. Click on "**Staying Healthy Assessment (SHA**)" toward the bottom of the listed options
    - Age and language-specific SHA questionnaires may be found on this page

Staying Healthy Assessment

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Do you breastfeed your baby?	Yes	No	Skip	
					Physical Activity
2	Are you concerned about your baby's weight?	No	Yes	Skip	
3	Does your baby watch any TV?	No	Yes	Skip	
					Safety
4	Does your home have a working smoke detector?	Yes	No	Skip	
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Do you breastfeed your baby?	Yes	No	Skip	
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
					Physical Activity
3	Are you concerned about your baby's weight?	No	Yes	Skip	
4	Does your baby watch any TV?	No	Yes	Skip	
					Safety
5	Does your home have a working smoke detector?	Yes	No	Skip	
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

Staying Healthy Assessment

1 –2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Do you breastfeed your child?	Yes	No	Skip	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
7	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
10	Does your home have a working smoke detector?	Yes	No	Skip	Safety
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
6	Does your child play actively most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
					Safety
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
12	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
14	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	

16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

	Nutrition				
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
	Physical Activity				
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
	Safety				
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

	Nutrition				
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
	Physical Activity				
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
	Safety				
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	

18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.					
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	Yes	No	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☐ Other *Please specify:*			Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *Please specify:*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

						Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip		Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip		
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip		
4	Are you easily able to get enough healthy food?	Yes	No	Skip		
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip		
6	Do you often eat too much or too little food?	No	Yes	Skip		
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip		
8	Are you concerned about your weight?	No	Yes	Skip		
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip		Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip		Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip		
12	Are family members or friends worried about your driving?	No	Yes	Skip		
13	Have you had any car accidents lately?	No	Yes	Skip		
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip		
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip		
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip		
17	Do you brush and floss your teeth daily?	Yes	No	Skip		Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip		Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip		

20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	
21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	Yes	No	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

DATE: _____

THIS REFERRAL IS VALID FOR 30 DAYS ONLY

MOLINA HEALTHCARE OF CALIFORNIA
DIRECT REFERRAL TO SPECIALIST

DIRECT REFERRALS ARE ONLY VALID TO A MOLINA HEALTHCARE CONTRACTED SPECIALIST

PATIENT NAME:	MEMBER ID:
Date of Birth (mm/dd/yyyy):	Address:
Phone Number:	
☐ Medi-Cal ☐ Medicare ☐ Dual Options ☐ Marketplace	
Referred To:	Specialty:
Phone Number:	Address:
Fax Number:	
Diagnosis:	ICD-9 Code:
ATTACH ALL NECESSARY CLINICAL INFORMATION TO THIS DIRECT REFERRAL	
Referring PCP:	Specialty:
Phone Number:	Address:
Fax Number:	

PLEASE NOTE: SPECIALISTS ARE REQUIRED TO SUBMIT REPORTS BACK TO THE REFERRING PCP

INSTRUCTIONS:

- Provide completed original form to Molina Healthcare member to be presented to Specialist.
- Forward a copy to referred Specialist.
- Place a copy in the Molina Healthcare member's medical record.

All out-of-network services require Prior Authorization (PA). Initial specialty consults and follow-ups for Bariatric Surgery, Pain Management, and Reconstructive or Cosmetic Surgery require PA. All other requests for initial specialty consults and follow-ups to contracted providers do not require PA.

Molina Healthcare/Molina Medicare of California
Prior Authorization/Pre-Service Review Guide
Effective: 01/01/2014

This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare/Molina Medicare Members.

*****Referrals to Network Specialists do not require Prior Authorization*****
*****Office visits to contracted (par) providers do not require Prior Authorization*****

Authorization required for services listed below.
Pre-Service Review is required for elective services.
Only covered services are eligible for reimbursement

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:** Inpatient, Partial hospitalization, Day Treatment, Intensive Outpatient Programs (IOP), Electroconvulsive Therapy (ECT).
  - Non MD/APRN BH Outpatient Visits & Community Based Outpatient programming: After initial evaluation for outpatient and home settings.
  - Medicare does not require authorization for outpatient behavioral health services.
- **Chiropractic Services**
- **Cosmetic, Plastic and Reconstructive Procedures (in any setting):** which are not usually covered benefits include but are not limited to tattoo removal, collagen injections, rhinoplasty, otoplasty, scar revision, keloid treatments, surgical repair of gynecomastia, pectus deformity, mammoplasty, abdominoplasty, venous injections, vein ligation, venous ablation, dermabrasion, Botox injections, etc.
- **Dental General Anesthesia:** >7 years old or per state benefit (Not a Medicare covered benefit).
- **Dialysis:** Notification only.
- **Durable Medical Equipment:** Refer to Molina's website for specific codes that require authorization.
  - Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462.
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing except** for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations.
- **Home Healthcare:** After 3 skilled nursing visits.
- **Home Infusion**
- **Hospice & Palliative Care:** Notification only.
- **Imaging:** CT, MRI, MRA, PET, SPECT, Cardiac Nuclear Studies, CT Angiograms, Intimal Media Thickness Testing, Three Dimensional (3D) Imaging.
- **Inpatient Admissions: Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility, Hospice** (Hospice requires notification only).
- **Long Term Services and Supports: (per state benefit)** e.g., Personal Attendant Services (PAS), Personal Care Services, Day Adult Health Services (DAHS). Not a Medicare covered benefit.
- **Neuropsychological and Psychological Testing and Therapy**
- **Non-Par Providers/Facilities: Office visits, procedures, labs, diagnostic studies, inpatient stays except for:**
  - Emergency Department services
  - Professional fees associated with ER visit, approved Ambulatory Surgery Center (ASC) or inpatient stay
  - Women's Health, Family Planning and Obstetrical Services
  - Child and Adolescent Health Center Services
  - Local Health Department (LHD) services
  - Other services based on state requirements
- **Nutritional Supplements & Enteral Formulas.**
- **Occupational Therapy**: After initial evaluation for outpatient and home settings
- **Office-Based Surgical Procedures do not require authorization except for Podiatry Surgical Procedures** (excluding routine foot care)
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures:** Refer to Molina's website for specific codes that are **EXCLUDED** from authorization requirements.
- **Pain Management Procedures:** including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (Acupuncture is not a Medicare covered benefit).
- **Physical Therapy:** After initial evaluation for outpatient and home settings.
- **Pregnancy and Delivery:** Notification only.
- **Prosthetics/Orthotics:** Refer to Molina's website for specific codes that require authorization. Includes but not limited to:
  - Orthopedic footwear/orthotics/foot inserts
  - Customized orthotics, prosthetics, braces
- **Rehabilitation Services:** Including Cardiac, Pulmonary, and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only.
- **Sleep Studies.**
- **Specialty Pharmacy drugs (oral and injectable) used to treat the following disease states, but not limited to: Anemia, Crohn's/Ulcerative Colitis, Cystic Fibrosis, Growth Hormone Deficiency, Hemophilia, Hepatitis C, Immune Deficiencies, Multiple Sclerosis, Oncology, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, and RSV prophylaxis:** Refer to Molina's website for specific codes that require authorization.
- **Speech Therapy:** After initial evaluation for outpatient and home settings.
- **Transplant Evaluation and Services including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation:** non-emergent ambulance (ground and air).
- **Unlisted and Miscellaneous Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Wound Therapy including Wound Vacs and Hyperbaric Wound Therapy.**

***STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with claim. (Medicaid benefit only)**

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE/MOLINA MEDICARE

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results)
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment 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 will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone/fax or electronic notification. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition.
- Providers can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at 800 526-8196

Important Molina Healthcare/Molina Medicare Contact Information

Medical Prior Authorizations: 8:00 a.m. – 5:00 p.m.
Phone: 888-665-4621 Fax: 800-811-4804

Radiology Authorizations:
Phone: 855-714-2415 Fax: 877-731-7218

NICU Authorizations:
Phone: 855-714-2415 Fax: 877-731-7218

Medical Pharmacy Authorizations:
Phone: 888-665-4621 Fax: 866-508-6445

Medicare Pharmacy Authorizations:
Phone: 888-665-1328 Fax: 866-290-1309

Transplant Authorizations:
Phone: 855-714-2415 Fax: 877-731-7218

Medical Member Customer Service Benefits/Eligibility:
Phone: 888-665-4621 Fax: 310-507-6168
TTY/TDD: 711

Medicare Member Customer Service
Phone: 800-665-0898 TTY/TDD: 711

Molina Dual Options Cal MediConnect Member Customer Service
Phone: 855-665-4627 TTY/TDD: 711

Provider Customer Service: 8:00 a.m. – 5:00 p.m.
Phone: 888 665-4621 Fax: 562 901-9632

24 Hour Nurse Advice Line
English: 888-275-8750 TTY: 866-735-2929
Spanish: 866-648-3537 TTY: 866-833-4703

Medical Vision:
Phone: 888-493-4070

Medicare Vision:
Phone: 800-327-4462

Medical Dental:
Phone: 800-423-0507

Medicare Dental:
Phone: 855-214-6779

Medicare Non-emergent Transportation:
Phone: 866-475-5423 Fax: 888 589-6164

Providers may utilize Molina Healthcare's ePortal at: www.molinahealthcare.com
Available features include:

- Authorization submission and status
- Claims submission and status (EDI only)
- Download Frequently used forms
- Member Eligibility
- Provider Directory
- Nurse Advice Line Report

Molina Healthcare of California – Medicaid / Medicare
Prior Authorization Request Form

Medical Fax Number: 800-811-4804
Medicare Fax Number: 866-472-0596
Radiology Fax Number: 877-731-7218

MEMBER INFORMATION			
Plan:	☐**Molina Medicaid**	☐**Molina Medicare**	☐**Other:**
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐Elective/Routine	☐Expedited/Urgent*	

***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.**

	Referral / Service Type Requested		
Inpatient ☐Surgical procedures ☐ER Admits ☐SNF ☐Rehab ☐LTAC	**Outpatient** ☐Surgical Procedure ☐Diagnostic Procedure ☐Wound Care ☐Other:	☐Rehab (PT, OT, & ST) ☐Chiropractic ☐Infusion Therapy	☐**Home Health** ☐**DME** ☐**In Office**

Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		Date(s) of Service:	

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Facility Providing Service:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -

For Molina Use Only:

MOLINA® HEALTHCARE

Pregnancy Notification Form

Today's Date: _____

Urgent - Time Sensitive

Upon confirmation of a positive pregnancy test, please complete the form and fax toll free to (855) 556-1424. If you have questions or need assistance, please call (877) 665-4628.

Member Information

Member's Name: _____ Member ID/CIN: _____

Member's DOB: _____ Preferred Language: _____

Phone #: ( ) _____ Alternate Phone #: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

LMP: _____ EDC: _____

IPA Name: _____

High Risk Condition(s)

Current Pregnancy

- ❑ Hypertension
- ❑ Diabetes
- ❑ Smoking
- ❑ Excessive Nausea & Vomiting
- ❑ 17 P Candidate (If +PTD)
- ❑ No problems with current pregnancy
- ❑ Pre-term labor
- ❑ Multiple Gestation
- ❑ Other: _____

Past Pregnancy

- ❑ N/A
- ❑ Hypertension
- ❑ Diabetes
- ❑ Pre-term labor
- ❑ Pre-term delivery
- ❑ No problems with past pregnancy
- ❑ Other: _____

Provider Information

Practitioner's Name: _____

Practitioner's Address: _____

Practitioner's Phone Number: _____

Date of First Prenatal Appointment Scheduled/Completed: _____

Referred to OB/GYN Practitioner: _____

Referred OB/GYN Practitioner Phone #: ( ) _____

MOLINA HEALTHCARE

Molina Healthcare of California
Contracted Hospitals

Los Angeles County

Hospital System	Hospital Name	City	Phone Number	Medi-Cal Managed Care	Molina Medicare Options Plus	Dual Options (Cal MediConnect)	Molina Marketplace (Covered CA)
AHMC Healthcare Inc.	Alhambra Hospital Medical Center	Alhambra	626-570-1606	✓	✓	✓	✓
	Garfield Medical Center	Monterey Park	626-573-2222	✓	✓	✓	✓
	Greater El Monte Medical Center	South El Monte	626-579-7777	✓	✓	✓	✓
	Monterey Park Hospital	Monterey Park	626-570-9000	✓	✓	✓	✓
	Whittier Hospital Medical Center	Whittier	562-945-3561	✓	✓	✓	✓
Alta Hospitals System LLC	Hollywood Community Hospital at Van Nuys	Van Nuys	818-787-1511	✓	✓	✓	
	Hollywood Community Hospital at Brotman Medical Center	Culver City	310-943-4500	✓	✓	✓	✓
	Hollywood Community Hospital at Hollywood	Hollywood	323-462-2271	✓	✓	✓	✓
	Los Angeles Community Hospital at Norwalk	Norwalk	562-863-4763	✓	✓	✓	✓
	Los Angeles Community Hospital at Los Angeles	Los Angeles	323-267-0477	✓	✓	✓	✓
Aurora Behavioral Health Care	Charter Oak Hospital (Behavioral Health Services Only)	Covina	626-967-3925		✓	✓	✓
	Las Encinas Hospital (Behavioral Health Services Only)	Pasadena	951-549-8032		✓	✓	✓
Avanti Hospital System	East Los Angeles Doctors Hospital	Los Angeles	323-268-5514	✓	✓	✓	✓
	Memorial Hospital of Gardena	Gardena	310-532-4200	✓	✓	✓	✓
California Hospital Association (CHA)	Hollywood Presbyterian Medical Center	Los Angeles	213-413-3000	✓	✓	✓	✓
College Enterprise	College Hospital of Cerritos (Behavioral Health Services Only)	Cerritos	562-924-9581		✓	✓	✓
	College Hospital of Costa Mesa (Behavioral Health Services Only)	Costa Mesa	949-642-2734		✓	✓	✓
	College Medical Center	Long Beach	562-997-2500	✓	✓	✓	✓
Dignity Health	St. Mary Medical Center	Long Beach	562-491-9000	✓	✓	✓	✓
Los Angeles County	Harbor - UCLA Medical Center	Torrance	310-222-1811	✓	✓	✓	✓
	LAC - USC Medical Center	Los Angeles	323-226-2622	✓	✓	✓	✓
	Olive View - UCLA Medical Center	Sylmar	818-364-1555	✓	✓	✓	✓
	Rancho Los Amigos National Rehabilitation	Downey	562-803-0124	✓	✓	✓	✓
Memorial Care Health System	Children's Hospital Los Angeles	Los Angeles	323-660-2450	✓	✓		
	Community Hospital Long Beach	Long Beach	562-498-1000	✓	✓	✓	
	Long Beach Memorial Medical Center	Long Beach	562-933-2000	✓	✓	✓	
	Miller Children's Hospital Long Beach	Long Beach	562-933-2000	✓	✓	✓	
Prime Healthcare Services	Centinela Hospital Medical Center	Inglewood	310-673-4660	✓	✓	✓	✓
	Encino Hospital Medical Center	Encino	818-995-5000	✓	✓	✓	✓
	San Dimas Community Hospital	San Dimas	909-599-6811	✓	✓	✓	✓
	Sherman Oaks Hospital	Sherman Oaks	818-981-7111	✓	✓	✓	✓
Providence Health & Services	Holy Cross Medi-Cal Center	Mission Hills	818-365-8051	✓			
	Little Company of Mary (San Pedro)	San Pedro	310-832-3311	✓			
	St. Joseph Medical Center	Burbank	818-843-5111	✓			
	Tarzana Medical Center	Tarzana	818-881-0800	✓			
Universal Health Services, Inc. (UHS)	Palmdale Regional Medical Center/Lancaster Community Hospital	Palmdale	626-359-8111	✓	✓	✓	
	Beverly Hospital	Montebello	323-726-1222	✓	✓	✓	✓
	City of Hope National Medical Center	Duarte	626-359-8111	✓			
	Downey Regional Medical Center	Downey	562-904-5000		✓		
	Methodist Hospital of South CA	Arcadia	626-445-4441	✓	✓	✓	
	Mission Community Hospital	Panorama	818-787-2222	✓			
	Pacific Alliance Medical Center	Los Angeles	213-624-8411	✓	✓	✓	✓
	Pacifica Hospital of the Valley	Sun Valley	818-767-3310	✓	✓		
	Pomona Valley Hospital Medical Center	Pomona	909-865-9500	✓			✓
	Silver Lake Medical Center	Los Angeles	213-989-6100	✓	✓	✓	✓
	Torrance Memorial Medical Center	Torrance	310-325-9110		✓	✓	
	Valley Presbyterian Hospital	Van Nuys	818-782-6600	✓	✓		✓

Molina Medical Group Specialist Roster

Los Angeles Region

#	SPECIALTY	GROUP NAME	LAST NAME	FIRST NAME	AGE LIMIT	ADDRESS	STE	CITY	ZIP	PHONE	FAX
1	Allergy & Immunology	Allergy Asthma Sinusitis Medical Center	Trivedi	Divyang	All ages	13330 Bloomfield Ave	210	Norwalk	90650	(562)864-4500	(562) 864-4959
2	Cardiology	Amarjeet S Kapoor MD Inc	Kapoor	Amarjeet	Only 18+	1045 Atlantic Ave	611	Long Beach	90813	(562)491-9840	(562) 432-0111
3	Cardiology	Krishna N Manvi and Parvataneni MD	Manvi	Krishna	All ages	2777 Pacific Ave	D	Long Beach	90806	(562)426-1792	(562) 427-4923
4	Cardiology	Krishna N Manvi and Parvataneni MD	Parvataneni	Arun	All ages	2777 Pacific Ave	D	Long Beach	90806	(562)426-1792	(562) 427-4923
5	Cardiology	Harbor UCLA Medical Foundation Inc	Budoff	Matthew	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
6	Dermatology	Keerthi R Desilva MD Inc	De Silva	Keerthi	All ages	1141 W. Redondo Beach Blvd	107	Gardena	90247	(310)515-0677	(310) 515-5033
7	Endocrinology, Diabetes & Metabolism	Linda T Wang MD Inc	Wang	Linda	Only 16+	2840 Long Beach Blvd	435	Long Beach	90806	(562)988-8787	(562) 988-8780
8	Endocrinology, Diabetes & Metabolism	Harbor UCLA Medical Foundation, Inc.	Gianoukaki	Andrew	All ages	21840 S. Normandie Ave.	100	Torrance	90502	(310)222-5002	(310) 328-1415
10	Gastroenterology	Digestive Health Specialist Inc	Shah	Anoop	Only 18+	1045 Atlantic Ave	907	Long Beach	90813	(562)491-9823	(562) 432-0111
11	Geriatrics	Harbor UCLA Medical Foundation Inc	Barrett	Peter	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
12	Hematology & Oncology	R. Nandan MD, Inc	Nandan	R	Only 18+	3650 E. South Street	212	Lakewood	90712	(562)272-7630	(562) 272-7631
13	Hematology & Oncology	The Oncologist Inst	Agajanian	Richy	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
14	Hematology & Oncology	The Oncologist Inst	Cheung	Eric	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
15	Hematology & Oncology	The Oncologist Inst	Chung	Michael	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
16	Hematology & Oncology	The Oncologist Inst	Farooq	Aamer	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
17	Hematology & Oncology	The Oncologist Inst	Freimann	Jack	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
18	Hematology & Oncology	The Oncologist Inst	Gaitanis	Alexander	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
19	Hematology & Oncology	The Oncologist Inst	Gamal	Youssef	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
20	Hematology & Oncology	The Oncologist Inst	Huang	Daniel	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
21	Hematology & Oncology	The Oncologist Inst	Huang	Stephen	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
22	Hematology & Oncology	The Oncologist Inst	Kim	Daniel	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
23	Hematology & Oncology	The Oncologist Inst	Mostofi	Reza	All ages	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
24	Hematology & Oncology	The Oncologist Inst	Rupani	Ravin	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
25	Hematology & Oncology	The Oncologist Inst	Shum	Merrill	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
26	Hematology & Oncology	The Oncologist Inst	Reynolds	Thomas	Only 18+	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
27	Hematology & Oncology	The Oncologist Inst	Vatanparast	Rodina		11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
28	Hematology & Oncology	The Oncologist Inst	Wali	Deepika	Only 18 +	11480 Brookshire Ave	309	Downey	90241	(562)869-1201	(562) 869-1281
29	Marriage & Family Therapist	Albert Potash MFT	Potash	Albert	All ages	24050 Madison Street	217	Torrance	90505	(310)373-4564	(310) 373-4564
30	Multi-specialty	Harbor UCLA Medical Foundation Inc				21840 S. Normandie Ave	100	Torrance	90502	(310)222-5125	(310) 222-2149
31	Neoatao-Perinatal Medicine	Maternal Fetal Medicine Associates	Ogundipe	Anthony	All ages	3628 E Imperial Hwy	200	Lynwood	90262	(310)602-3435	(310) 603-2344
32	Nephrology	Andy Hong MD	Hong	Andy	Only 18+	3625 Martin Luther King Jr	5	Lynwood	90262	(310)763-7504	(310) 763-7573
33	Nephrology	Coast Nephrology Medical Group	Erlbaum	Alan	All ages	3780 Kilroy Airport Way	115	Long Beach	90806	(562)595-7426	(562) 959-3054
34	Nephrology	Coast Nephrology Medical Group	Zoller	Karen	Only 16+	3780 Kilroy Airport Way	115	Long Beach	90806	(562)595-7426	(562) 959-3054
35	Nephrology	Coast Nephrology Medical Group	Hsieh	John	Only 16+	3780 Kilroy Airport Way	115	Long Beach	90806	(562)595-7426	(562) 959-3054

Molina Medical Group Specialist Roster

Los Angeles Region

#	SPECIALTY	GROUP NAME	LAST NAME	FIRST NAME	AGE LIMIT	ADDRESS	STE	CITY	ZIP	PHONE	FAX
36	Nephrology	Coast Nephrology Medical Group	Maasarami	Essam	Only 16+	3780 Kilroy Airport Way	115	Long Beach	90806	(562)595-7426	(562) 959-3054
37	Nephrology	Coast Nephrology Medical Group	Park	Alice	Only 16+	3780 Kilroy Airport Way	115	Long Beach	90806	(562)595-7426	(562) 959-3054
38	Nephrology	Preferred Nephrology Medical Group	Daswani	Adarsh	All ages	3300 E. South Street	110	Long Beach	90805	(562)630-7279	(562) 630-8828
39	Nephrology	Preferred Nephrology Medical Group	Lee	Tae	All ages	3300 E. South Street	110	Long Beach	90805	(562)630-7279	(562) 630-8828
40	Nephrology	Preferred Nephrology Medical Group	Hsu	Alex	Only 18 +	3300 E. South Street	110	Long Beach	90805	(562)630-7279	(562) 630-8828
41	Nephrology	Renal Medical Associates A Medical Partnership	Khwaja	Samia	All ages	3625 E. Martin Luther King Blvd	2	Lynwood	90262	(310)638-0535	(310) 638-9171
42	Nephrology	Renal Medical Associates A Medical Partnership	Guadiz	Ramon	All ages	3625 E. Martin Luther King Blvd	2	Lynwood	90262	(310)638-0535	(310) 638-9171
43	Nephrology	Renal Medical Associates A Medical Partnership	Rocha	Rodrigo	Only 18+	3625 E. Martin Luther King Blvd	2	Lynwood	90262	(310)638-0535	(310) 638-9171
44	Nephrology	Renal Medical Associates A Medical Partnership	Yanamadala	Sita	Only 18+	3625 E. Martin Luther King Blvd	2	Lynwood	90262	(310)638-0535	(310) 638-9171
45	Nephrology	Stephen Lui MD	Lui	Stephen	Only 18+	3625 Martin Luther King Jr Blvd	5	Lynwood	90262	(310)763-7504	(310) 763-7573
46	Neurology	Prentice Mitri and Hijazin Neurological Associates	Mitri	Antoine	All ages	11525 Brookshire Ave	205	Downey	90241	(562)861-1988	(562) 861-5835
47	Neurology	Harbor UCLA Medical Foundation Inc	Diaz	Natalie	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
48	Neurology	Harbor UCLA Medical Foundation Inc	Mehta	Bajal		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
49	Obstetrics & Gynecology	N.N. Bhatia MD Inc	Bhatia	Narender	All ages	3650 Atlantic Ave		Long Beach	90807	(562)426-5630	(562) 492-9893
50	Obstetrics & Gynecology	Reproductive Associates Medical Group	Sohl	Bertram	Only 14+	1045 Atlantic Ave	508	Long Beach	90813	(562)437-1882	(562) 437-5412
51	Obstetrics & Gynecology	Reproductive Associates Medical Group	Emamian	Mohammad	Only 14+	1045 Atlantic Ave	508	Long Beach	90813	(562)437-1882	(562) 437-5412
52	Obstetrics & Gynecology	Reproductive Associates Medical Group	Mizrahi	Rabin	Only 14+	1045 Atlantic Ave	508	Long Beach	90813	(562)437-1882	(562) 437-5412
53	Obstetrics & Gynecology	SL Health Inc	Cogan	Michael	All ages	2683 Pacific Ave	A	Long Beach	90806	(562)989-5722	(562) 989-5732
54	Obstetrics & Gynecology	Son Ha and Diem Chi A Medical Corp	Nguyen	Ha	All ages	1951 Pacific Ave		Long Beach	90806	(562)218-8778	(562) 218-1916
55	Ophthalmology	Coastal Vision Medical Group	Tran	Dan		709 E. Anaheim Street		Long Beach	90813	(562)591-7700	(562) 591-1311
56	Ophthalmology	Coastal Vision Medical Group	Doan	Tu	All ages	709 E. Anaheim Street		Long Beach	90813	(562)591-7700	(562) 591-1311
57	Ophthalmology	Coastal Vision Medical Group	Garbutt	Lisa	All ages	709 E. Anaheim Street		Long Beach	90813	(562)591-7700	(562) 591-1311
58	Ophthalmology	Retina Vitreous Associates Medical Group	Liao	David	All ages	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
59	Ophthalmology	Retina Vitreous Associates Medical Group	Rahhal	Firas	All ages	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
60	Ophthalmology	Retina Vitreous Associates Medical Group	Tabandeh	Homayoun	All ages	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
61	Ophthalmology	Retina Vitreous Associates Medical Group	Roe	Richard	All ages	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
62	Ophthalmology	Retina Vitreous Associates Medical Group	Chu	Thomas	All ages	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
63	Ophthalmology	Retina Vitreous Associates Medical Group	Novack	Roger	Only 18 +	1127 Wilshire Blvd.	1620	Los Angeles	90017	(213)483-8810	(213) 975-9118
64	Ophthalmology	Robert L Charet MD	Charet	Robert	All ages	12954 Hawthrone Blvd	103	Hawthrone	90250	(310)676-1373	(310) 676-1914
65	Orthopeadic Surgery	Edward Christopher Kolpin DO Inc	Kolpin	Edward	Only 18+	4511 Rosemead Blvd.		Pico Rivera	90660	(559)325-3040	(310) 626-6904
66	Otolaryngology	Elias I Ayoub MD FACS	Ayoub	Elias	All ages	11480 Brookshire Ave	303	Downey	90241	(562)862-5160	(562) 923-8205
67	Pediatric Cardiology	Harbor UCLA Medical Foundation, Inc.	Atkinson	David	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
68	Pediatric Cardiology	Harbor UCLA Medical Foundation Inc	Baylen	Barry	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
69	Pediatric Cardiology	Harbor UCLA Medical Foundation, Inc.	Chang	Ruey-Kang	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415

Molina Medical Group Specialist Roster

Los Angeles Region

#	SPECIALTY	GROUP NAME	LAST NAME	FIRST NAME	AGE LIMIT	ADDRESS	STE	CITY	ZIP	PHONE	FAX
70	Pediatric Cardiology	Pediatric Heart Center	Banks	Aaron	Only 21 ar	575 E. Hardy Street	201	Inglewood	90301	(661)664-0808	(855) 329-2742
72	Pediatric Endocrinology	Harbor UCLA Medical Foundation, Inc.	Mao	Catherine	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
73	Pediatric Genetics (Medical)	Harbor UCLA Medical Foundation, Inc.	Lin	Henry		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
74	Pediatric Genetics (Medical)	Harbor UCLA Medical Foundation, Inc.	Jonas	Adam		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
75	Pediatric Infectious Disease	Harbor UCLA Medical Foundation Inc	Mink	ChrisAnna	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
76	Pediatric Neurology	Harbor UCLA Medical Foundation, Inc.	Huff	Kenneth	Only 19 ar	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
77	Pediatric - Surgery - General	Harbor UCLA Medical Foundation Inc	Lee	Steven	Only 19 ar	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
78	Pediatric - Surgery - General	Harbor UCLA Medical Foundation, Inc.	Asch	Morris		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
79	Plastic Surgery	Ronald F Rosso MD A Med Corp	Rosso	Ronald	All ages	3400 W. Lomita Blvd	306	Torrance	90505	(310)326-3636	(310) 326-6448
80	Pain Management	Behnoush Zarrini, MD, Inc	Zarrini	Behnoush	All ages	8900 Wilshire Blvd	204	Beverly Hills	90211	(310)409-3537	(310) 287-9899
81	Podiatrist	Connie Wong DPM and Ki Sang Yi DPM Inc	Wong	Connie	All ages	1703 Termino Ave	103	Long Beach	90804	(562)597-5100	(562) 597-5165
82	Podiatrist	Mark S. Linam, DPM A Professional Corporation	Linam	Mark	All ages	16660 Paramount Blvd	101	Paramount	90723	(562)633-0976	(562) 633-8470
83	Psychiatry	Maurice I Zeitlin, MD A Medical Corporation	Zeitlin	Maurice		Molina Clinic					
84	Pulmonary Medicine	Harbor UCLA Medical Foundation, Inc.	Mason	Gregorgy	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
85	Pulmonary Medicine	Harbor UCLA Medical Foundation, Inc.	Vintch	Janine	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
86	Radiation Oncology	Radiation Oncology Associates	Dave	Sulabha	Only 18+	2449 E South Street		Long Beach	90805	(562)633-0836	(562) 633-8345
87	Radiation Oncology	St Mary Radiation Oncology DBA Coastline Radia	Gates	Thomas	Only 18+	1043 Elm Ave	110	Long Beach	90813	(562)491-9890	(562) 491-9091
88	Radiology (outpatient)	College Medical Center				2776 Pacific Ave		Long Beach	90806	(562)997-2000	(562) 216-5699
89	Surgery - Colon/Rectal	Harbor UCLA Medical Foundation, Inc.	Kumar	Ravin		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
90	Surgery- General	Gregory Chambers MD A Medical Corp	Chambers	Gregorgy	Only 18+	1045 Atlantic Ave	712	Long Beach	90813	(562)491-4879	(562) 491-7987
91	Surgery- General	James A Murray MD	Murray	James	Only 5+	1045 Atlantic Ave	712	Long Beach	90813	(562)491-4879	(562) 491-7987
92	Surgery - Neurological	Daniel R Lemay MD PHD Inc	Lemay	Daniel	Only 5+	8043 2nd Street	105	Downey	90241	(562)862-1134	(562) 861-9895
93	Surgery - Neurological	Duc H Duong MD Inc	Duong	Duc	Only 5+	8043 2nd Street	105	Downey	90241	(562)862-1134	(562) 861-9895
94	Surgery- Thoracic & Vascular	TCS Medical Group	Panagiotides	George	Only 17 +	3650 South Street	206	Lakewood	90712	(562)531-0019	(562) 431-0032
95	Surgery - Thoracic & Vascular	Vascular and Thoracic Associates	Marrocco	Christopher	All ages	3680 E Imperial Hwy	502	Lynwood	90262	(562)698-0271	(562) 698-7467
96	Urology	Asghar Askari MD	Askari	Asghar	All ages	1360 W 6th Street	160	San Pedro	90732	(310)519-9180	(310) 519-0225
97	Urology	Harbor UCLA Medical Foundation, Inc.	Blumberg	Jeremy	All ages	21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
98	Urology	Harbor UCLA Medical Foundation Inc	Raifer	Jacob		21840 S. Normandie Ave	100	Torrance	90502	(310)222-5002	(310) 328-1415
99	Urology	Atlantic Urology Medical Group	Wachs	Barton	Only acce	701 E. 28th Street	319	Long Beach	90806	(562)595-5977	(562) 490-0509
100	Urology-Gynocology	N.N. Bhatia MD Inc	Bhatia	Narender	All ages	3650 Atlantic Ave		Long Beach	90807	(562)426-5630	(562) 492-9893

CLAIMS GUIDELINES

Claims Processing Standards

On a monthly basis, 90% of Medi-Cal claims received by Molina are processed within thirty (30) calendar days. 100% of claims are processed within forty-five (45) working days. These standards must be met in order for Molina to remain compliant with State requirements and ensure timely pay.

Claims Filing Timeframe

Molina Medical Group (MMG) will accept complete claims from Providers for processing if received within one hundred and eighty (180) days following the date of service. Provider shall promptly submit to MMG, claims for covered services rendered to MMG members. All claims shall be submitted in a form acceptable to and approved by MMG, and shall be complete including any applicable medical records pertaining to the claim as required by MMG's policies and procedures.

Any claims that are not submitted by the Provider to MMG within one hundred eighty (180) days of providing the covered services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

Claims Submission Options

1. Online Submission: www.MolinaHealthcare.com
   Please register online to begin

2. Clearing House (Emdeon)
   - Emdeon is an outside vendor that is used by Molina Medical Group
   - When submitting EDI Claims (via a clearinghouse) to Molina Molina Medical Group, please utilize the following payer ID **38333.**
   - EDI or Electronic Claims get processed faster than paper claims

   Providers can use any clearinghouse of their choosing. Please note that fees may apply.

3. Hard Copy CMS 1500 Professional claims, please mail to:

Molina Medical Group Attn: Claims Department P.O. Box 22693 Long Beach, CA 90801	**or**	Molina Medical Group Attn: Claims Department P.O. Box 22702 Long Beach, CA 90801

Claims Processing

MMG will adjudicate each complete claim or portion thereof according to the agreed upon contract rate, no later than forty five (45) working days after receipt unless the claim is contested or denied. If a claim is contested or denied, the provider will receive a written determination stating the reasons for this status no later than forty five (45) working days after receipt.

EDI Claim Submission Issues

- Please call the EDI customer service line at (866) 409- 2935 and/or submit an email to: EDI.Claims@MolinHealthcare.com
- Contact your respective county provider services representative

Provider Disputes

The purpose of Provider Dispute Resolution (PDR) is to:

- Provide a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes
- Research and resolve disputes in accordance with 1300.71.38 California Code of Regulations (CCR) - AB 1455 claims Settlement Practices and Dispute Resolution Mechanism.

A Provider Dispute is defined as a written notice prepared by a provider that:

- Challenges, appeals, or requests reconsideration of a claim that has been denied, adjusted, or contested.
- Challenges a request for reimbursement for an overpayment of a claim
- Seeks resolution of a billing determination or other contractual dispute

Molina Healthcare will acknowledge the receipt of the dispute if submitted within **three hundred sixty five (365) days** from the last date of action on the issue.

All Provider disputes require the submission of a Provider Dispute Resolution Request Form or a Letter of Explanation, which serves as a written first level appeal by the Provider. For paper submission, MMG will acknowledge receipt of the dispute within **fifteen (15) working days**. If additional information is needed from the Provider, MMG has **forty five (45) working days** to request necessary additional information. Once notified in writing, the Provider has **thirty (30) working days** to submit additional information or claim dispute will be closed by MMG.

- Molina will address providers concerns in a timely, accurately and effective manner.
- Identification of trends (root cause) will be communicated in an effort to reduce future claim errors and assist in the reduction of future PDR submissions.

The Provider Dispute Resolution Request form can be accessed at www.MolinaHealthcare.com on the forms tab.

Claims Customer Service & Provider Disputes

- For assistance with any claims related processes or individual claims issues, please contact Claims Customer Services at: (855) 322-4075, Ext 751123.

- If you would like a Claims Department to research related issues, you also have the option of submitting a Special Project. Please submit all Medi-Cal and contracted Medicare claims Special Projects to: MHC_SpecialProjects@MolinaHealthcare.com or fax (562) 499-0603.

- Please include the following components in your submission:

  - Claim Number
  - Date of Service
  - Member Name
  - Member ID
  - Billed amount
  - Paid amount (if any)
  - Comments/reason for project

For assistance with any claims related processed, please contact:

James Loopeker……. (562) 491-7069
Manager, Provider Inquiry Research & Resolution

If you need to file a formal **Provider Dispute**, please send to:

Medi-Cal:
P.O. Box 22722
Long Beach, CA 90801
Attn: Provider Dispute Resolution Unit

Medicare:
P.O. Box 22817
Long Beach, CA 90801
Attn: Provider Appeals

MOLINA HEALTHCARE

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute..
- For routine follow-up, please use the Provider Tracking Form instead of the Provider Dispute Resolution Form.
- Mail the completed form to: Molina Healthcare of California
  P.O. Box 22722
  Long Beach, CA 90801
  ATTN: Provider Dispute Resolution

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab

☐ Home Health ☐ Ambulance ☐ Other _____

(please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:___

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

For Health Plan Use Only

TRACKING NUMBER
PROVIDER ID#

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple additional information)

Revise:08/2010

ENCOUNTER DATA SUBMISSION

Encounter Reporting

The collection of encounter data is vital to MMG/ MHC. Encounter data provides MMG/MHC with information regarding all services provided to our membership.

Encounter data serves several critical needs, it provides:

- Information on the utilization of services
- Information for use in HEDIS studies
- Information that fulfills state reporting requirements

Procedure

Single encounter (for our purposes) is defined as all services performed by a single Provider on a single date of service for an individual member.

The following guidelines are provided to assist our Providers with submission of complete encounter data:

- Reporting of services must be done on a per member, per visits basis
- A reporting of all services rendered by date must be submitted to MMG
- Encounter Data must reflect same data elements required under a fee-for service program
- All encounter data reporting is subject to, and must be in full compliance with, the Health Insurance Portability and Accountability Act and any other regulatory reporting requirements

Electronic Encounter Reporting Submission

- Data must be submitted via our File Exchange Services (FES) site in the HIPPA compliant 837 format (ASC X12N 837).
- Electronic encounter data must be received no later than ninety (90) days from end of month following the encounter (e.g. by October 31st for all encounters occurring in July).
- Only encounter records that pass MMG/MHC edits will be included in the records evaluated for compliance. Encounters that fail MHC edits will be rejected and error reports will be made available via our File Exchange Services (FES) site or our E-Portal Services at www.MolinaHealthcare.com. If the failed encounter is corrected and resubmitted within the required timeframe, it will then be included in the calculation for performance standards. Please note that ONLY the corrected encounters are to be resubmitted.
- In no event will incomplete, inaccurate data be accepted.

Hard Copy Submission

- Hard copy encounter data for all capitated services must be submitted on a CMS 1500 or UB 04 form only.
- Hard copy encounter data must be received by the 5th day of the second month following the date of the encounter (e.g.) by September 5th for all encounters occurring in July).

LANGUAGE ASSISTANCE

Instructions on how to access language interpreter services will be provided soon.

In the meantime, if your patient requires such interpreter services please call member services during normal business hours:

Member Services:

(800) 675-6110 [Medi-Cal]

(855) 322-4075 [Marketplace]

(800) 665-0898 [Medicare]

(855) 655-4627 [Dual Options]