BH Prior Authorization Request Form – Molina Healthcare of Illinois, Inc.

Providers are strongly encouraged to use Molina Healthcare's Availity Essentials Provider Portal.

Log Into Availity Provider Portal:

- **Authorization Submission and Status**
- **Claims Submission and Status**
- **Member Eligibility, and much more**

MMP/Medicaid Phone: (855) 866-5462	MMP - Inpatient Fax: (844) 834-2152	MMP - Outpatient Fax: (844) 251-1451	Non-Emergent Transportation: MTM Phone: (844) 644-6354 – MTM Fax: (877) 406-0658

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **MMP/Duals**	**Date of Request:**
State/Health Plan (i.e. IL):	Molina Healthcare of Illinois			
Member Name:				**DOB (MM/DD/YYYY)**
Member ID:				**Member Phone:**

Service Type: (check one)

☐ Non-Urgent/Routine/Elective
☐ Urgent/Expedited–Clinical Reason: ______________________________
☐ Inpatient ER Admission (Concurrent)
☐ EPSDT/Special Services
☐ Other (Please Specify):

REFERRAL/SERVICE TYPE REQUESTED

Request Type: ☐ **Initial Request** ☐ **Extension/Renewal/Amendment—Previous Auth No.:**

Inpatient Services:

☐ Inpatient Psychiatric
☐ Involuntary ☐ Voluntary
☐ Inpatient Detoxification
☐ Involuntary ☐ Voluntary
Court Date: ____________________
☐ Residential Treatment (ASAM 3.5)
☐ Subacute Detox (ASAM 3.7)

Outpatient Services:

☐ Residential Treatment
☐ Partial Hospitalization Program
☐ Intensive Outpatient Program
☐ Day Treatment
☐ Assertive Community Treatment Program
☐ Targeted Case Management

☐ Electroconvulsive Therapy
☐ Psychological/Neuropsychological Testing
☐ Applied Behavioral Analysis
☐ Non-Par Outpatient Services
☐ Other:____________________

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

Dates Of Service Start	Stop	Procedure/Services Codes	Diagnosis Code	Requested Service	Requested Units/Visits

PROVIDER INFORMATION

Requesting/Referring Provider/Facility:

Provider Name:	**NPI:**	**TIN:**
Contact Person's Name:		
Phone:	**Fax:**	**Email:**

Address:	**City:**	**State:**	**ZIP:**

Requesting/Referring Provider/Facility:

PCP Name:	**PCP Phone:**
Office Contact Name:	**Office Contact Phone:**

Servicing/Billing Provider/Facility:					
Servicing Provider/Facility Name (Required):					
Contact Person's Name:					
NPI:		**TIN:**		**Medicaid ID (If Non-Par):** ☐ Non-Par ☐ COC	
Phone:	**Fax:**		**Email:**		
Address:		**City:**		**State:**	**ZIP:**

All fields are required and must be completed. Incomplete forms will be rejected.

For Molina Use Only:

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per plan policy and procedures. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions, and other applicable standards during the claim review, including the terms of any applicable provider agreement.

By requesting prior authorization, the provider is affirming that the services are medically necessary; a covered benefit under the Medicare and/or Medicaid Program(s), and the servicing provider is enrolled in those programs as eligible for reimbursement. As a condition of authorization, for services that are primary to Medicare, the out-of-network provider agrees to accept no more than 100% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the Date(s) of Service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co - payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member was enrolled in the Medicare Fee-For-Service Program. If the service is primary to Medicaid, the out-of-network agrees to accept no more than the amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of Illinois in effect on the Date(s) of Service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Molina Healthcare will not reimburse providers for services that are not deemed medically necessary. Servicing providers also recognize that Molina Healthcare members are not to be balanced billed for any uncollected monies for covered services pursuant to Medicare and Medicaid billing guidelines.