Pharmacy 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

MEMBER INFORMATION

MHIL Line of Business:	☐ Medicaid	☐ Marketplace	☐ MMP/Duals	Date of Request:

Member Name:	DOB:	Date:
Member ID:	Sex:	Weight: Height:
Member Phone:		

PROVIDER INFORMATION

Prescriber Name/Specialty:	NPI:	Office Contact Name:
Prescriber Address:	Office Phone:	Office Fax:
Treatment Facility Name:	IL Medicaid Certified: ☐ Yes ☐ No	
Treatment Facility NPI:	Treatment Facility TIN:	

MEDICATION REQUESTED

Drug Name:	Strength:	Directions (Sig):
Qty: Refills:	ICD-10 & Diagnosis Name:	
☐ New Request ☐ Reauthorization	Previous Auth No.:	

COMPLETE THE FOLLOWING SECTION ONLY IF BUY AND BILL (DRUG NOT DISPENSED VIA A PHARMACY)

HCPCS Code:

Number of Units Requested: Date(s) of Service:

Service Type (choose one):

☐ Elective/Routine: Determination **within 96 hours** from receipt of all necessary information.

☐ Expedited/Urgent: I hereby certify the request **is urgent and medically necessary** to treat an injury, illness, or condition (**not** life-threatening) **within 48 hours** to avoid complications and unnecessary suffering or severe pain.

PATIENT PREVIOUS MEDICATION(S) RELEVANT TO THIS REQUEST (COMPLETE FOR ALL REQUESTS)

Drug Name	Strength	Directions (Sig)	Duration Outcome & Reason for Discontinuation (Clinical Documentation Required)
1			
2			
3			

Use of drug samples will **not** be considered as rationale for approving a prior authorization request.
Length of treatment/failure with dates **must be** supported in clinical documentation (chart notes).

REQUIRED

Medical Rationale for Request/Additional Clinical Information (including diagnostic studies, lab results, & progress notes). Requests **will not** be processed if **any** of the information is missing: member information, provider information, or clinical documentation (chart notes). To ensure a timely response, please fill out the form completely and legibly.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.

Signature:

*****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.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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.