

Molina[®] Healthcare, Inc. – Prior Authorization Request Form

Requests for prior authorization should be sent via the [Availity Essentials portal](#).

- Claims Submission and Status
- Authorization Submission and Status
- Member Eligibility

MEMBER INFORMATION

Line of Business:	☐ Duals	☐ Medicare	☐ CA EAE (Medicaid)	Date of Request:
State/Health Plan (i.e. CA):				
Member Name:				DOB (MM/DD/YYYY)
Member ID#:				Member Phone:
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent ☐ Inpatient ER Admission (Concurrent) ☐ EPSDT/Special Services ☐ CA IPA request: Medicare Denial, requires Medicaid/LTC Review			☐ Continuity of Care (COC)

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ Initial Request	☐ Extension/Renewal/Amendment	☐ Previous Auth #
Inpatient Services:	Outpatient Services:		
☐ Inpatient Hospital ☐ Inpatient Transplant ☐ Inpatient Hospice ☐ Long Term Acute (LTAC) ☐ Acute Inpatient Rehabilitation (AIR) ☐ Skilled Nursing (SNF) ☐ Other Inpatient: _____	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Electroconvulsive Therapy ☐ Genetic Testing ☐ Home Health ☐ Hospice ☐ Hyperbaric Therapy ☐ Imaging/Special Tests	☐ Infusion Therapy ☐ Intensive Outpatient Program ☐ Laboratory Services ☐ LTSS Services ☐ Occupational Therapy ☐ Office Procedures ☐ Outpatient Surgical/Procedures ☐ Pain Management ☐ Palliative Care ☐ Pharmacy	☐ Partial Hospitalization Program ☐ Physical Therapy ☐ Radiation Therapy ☐ Speech Therapy ☐ Transplant/Gene Therapy ☐ Transportation ☐ Wound Care ☐ Other:

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: Description:

DATES OF SERVICE		PROCEDURE/SERVICES CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
Start	Stop				

PROVIDER INFORMATION

Requesting/Referring Provider/Facility:				
Provider Name:		NPI#:		TIN#:
Phone:		Fax:	Email:	
Address:	City:		State:	Zip:
PCP Name:		PCP Phone:		
Office Contact Name:		Office Contact Phone:		
Servicing/Billing Provider/Facility:				
Provider/Facility Name (Required):				
NPI#	TIN#	Medicaid ID# (If Non-Par):		☐ Non-Par ☐ COC
Phone:		Fax:	Email:	
Address:	City:		State:	Zip:

For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. 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.