



Molina Healthcare – Behavioral Health Request Form

Phone: 855-322-4077 Fax: 800-594-7404

Member Information

Member Name:		DOB:
Member ID#:		Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited	

Service Requested

Outpatient Services:	
<input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Other: _____ <input type="checkbox"/> Continuation of Care (COC) – Non par provider requesting services for COC	<p>Note: Inpatient Psychiatric and Detoxification services are rendered through the PIHPs.</p> <p>Outpatient Treatment, Partial Hospitalization, Intensive O/P, Day Treatment and Assertive Community Treatment Programs are rendered through the PIHPs.</p>

Date of Service	Diagnosis Code	Procedure/HCPC Code	Service Description	Requested Units/Visits

Provider Information

Requesting Provider/Facility: (Decision will be sent to the requesting provider/facility)				
Provider Name:	NPI#:	TIN#:		
Phone:	Fax:			
Address:	City:	State:	Zip:	
Office Contact Name:		Office Contact Phone:		
Servicing Provider/Facility:				
Provider/Facility Name:	NPI#:	TIN#:		
Phone:	Fax:			
Address:	City:	State:	Zip:	

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 specialty consultation notes.
- Any other information or data specific to the request.