

## Molina® Healthcare, Inc. – Pharmacy Prior Authorization Request Form

Providers may utilize [Molina's Provider Portal](#):

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

### MEMBER INFORMATION

<b>Line of Business:</b>	<input type="checkbox"/> Duals	<input type="checkbox"/> Medicare	<b>Date of Request:</b>
<b>State/Health Plan (i.e. CA):</b>			
<b>Member Name:</b>			<b>DOB (MM/DD/YYYY)</b>
<b>Member ID#:</b>			<b>Member Phone:</b>
<b>Service Type:</b>	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent <input type="checkbox"/> Inpatient ER Admission (Concurrent) <input type="checkbox"/> EPSDT/Special Services <input type="checkbox"/> Other (Please Specify):		

### REFERRAL/SERVICE TYPE REQUESTED

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

<b>Provider Name:</b>		<b>NPI#:</b>	<b>TIN#:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>PCP Name:</b>		<b>PCP Phone:</b>	
<b>Office Contact Name:</b>		<b>Office Contact Phone:</b>	

**Servicing/Billing Provider/Facility:**

<b>Provider/Facility Name (Required):</b>			
<b>NPI#</b>	<b>TIN#</b>	<b>Medicaid ID# (If Non-Par):</b>	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip:</b>

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.