



Molina® Healthcare Medicaid
Pre-Service Review Guide
Effective: 01/01/2026

Refer to Molina's Provider Website or Prior Authorization Look-Up Tool for specific codes that require Prior Authorization
Only covered services are eligible for reimbursement

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS
DO NOT REQUIRE PRIOR AUTHORIZATION.
EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient (requires notification and concurrent review), Residential Treatment, Partial hospitalization, Day Treatment
 - Intensive Outpatient requires review after 16 visits (use WI specific IOP code per Forward Health, effective 3/1/2025).
 - Targeted Case Management
 - Electroconvulsive Therapy (ECT)
 - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD) – carved out
- **Cardiology¹:** Select services are administered by Evolent.
- **Cosmetic, Plastic and Reconstructive Procedures:** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
FYI: Select CGM supplies: No PA required within product utilization limits for members with gestational or insulin-dependent diabetes (claim diagnosis must support). Refer to PA Look-Up Tool.
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)** PA required after initial evaluation plus 6 visits
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (per State benefit).** All LTSS services require PA regardless of code(s).
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale should be submitted with the prior authorization request.
- **Non-Par Providers:** With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
 - Local Health Department (LHD) services
 - Hospital Emergency services
 - Evaluation and Management services associated with inpatient, ER, and observation stays or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
 - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23 or 24, 51, 52
 - Other State mandated services
- **Nursing Home/Long Term Care**
- **Occupational, Physical & Speech Therapy** PA required after initial evaluation plus 12 visits
- **Oncology**
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Sleep Studies**
- **Transplants/Gene Therapy, including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** Non-emergent air transportation.

STERILIZATION NOTE: Federal guidelines require that at least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed. The consent form must be submitted with the claim.

¹ Services provided by Evolent - Cardiology Authorizations for Adults

IMPORTANT INFORMATION FOR MOLINA MEDICAID PROVIDERS

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 lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.

Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (855) 326-5059.

IMPORTANT MOLINA HEALTHCARE MEDICAID CONTACT INFORMATION

(Service hours 8am-5pm local M-F, unless otherwise specified)

**Inpatient and Outpatient Prior Authorizations including
Behavioral Health Authorizations:**

Phone: (855) 326-5059
Fax: (877) 708-2117

Radiology Authorizations:

Phone: (855) 714-2415
Fax: (877) 731-7218

Dental:

Phone: (888) 999-2404 for Milwaukee, Kenosha, Racine, Waukesha, Washington and Ozaukee.
Outside of these counties, call (800) 362-3002

ProgenyHealth

NICU Authorizations
Phone: (888) 832-2006
Fax: (866) 803-1125

Evolent:

Cardiology Authorizations for adults
Phone: (888) 999-7713
Fax: (877) 622-6879
Portal: <https://my.newcenturyhealth.com>

Member Customer Service, Benefits/Eligibility:
Phone: (888) 999-2404/ TTY: 711**Transportation:**
Phone: (866) 907-1493 (non-emergency medical transportation is carved out to State)**24 Hour Behavioral Health Crisis (7 days/week):**

Phone: (414) 257-7222

Transplant Authorizations:

Phone: (855) 714-2415
Fax: (877) 813-1206

Vision:

Phone: (844) 859-5870/TTY: 711

Provider Customer Service:

Phone: (855) 326-5059

Pharmacy Authorizations:

Phone: (800) 947-9627 (covered by Forward Health) (855) 326-5059 (covered by HMO)
Fax: (877) 708-2117 (HMO covered only)

24 Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750/TTY: 711

Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members. *No referral or prior authorization is needed.*



Providers may utilize Molina Healthcare's Website at: <https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- Authorization submission and status
- Member Eligibility
- Provider Directory
- Claims submission and status
- Download Frequently used forms
- Nurse Advice Line Report

Molina® Healthcare, Inc. – Pre-Service Request Form

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	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/Expedited – Clinical Reason for Urgency Required: _____ EPSDT/Special Services Qualifying Clinical Trial (Urgent/Expedited)			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Hospital (elective) Maternity/OB Notification (include baby stats for Medicaid LOB) <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (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"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care <input type="checkbox"/> Pharmacy J Codes (Outpatient Hospital/Provider – Refer to Forward Health PAD) <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Sleep Study <input type="checkbox"/> Sleep Equipment	<input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____ <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy # of therapy visits used YTD: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code:

Description:

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

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY: (DECISION WILL BE FAXED TO THE REQUESTING PROVIDER/FACILITY)

Provider Name:	NPI#:		TIN#:	
Phone:	FAX:		Email:	
Address:	City:		State:	Zip:
PCP Name:	PCP Phone:			
Office Contact Name:	Office Contact Phone:			



SERVICING PROVIDER / FACILITY: (Billing Provider/Facility)

Provider/Facility Name (Required):

Billing NPI# (required):	Billing TIN#:	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Phone:	FAX:	Email:	
Address:	City:	State:	Zip:

For Molina Use Only:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting



Molina® Healthcare, Inc. – BH Pre-Service and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	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/Expedited – Clinical Reason for Urgency Required: _____ Emergent Inpatient Admission Qualifying Clinical Trial (Urgent/Expedited)			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary	<input type="checkbox"/> Day Treatment # of days per week: # of hours per week: <input type="checkbox"/> Partial Hospitalization Program # of days per week: # of hours per week: <input type="checkbox"/> Intensive Outpatient Program (note IOP specific code per Forward Health) # of days per week: # of hours per week: <input type="checkbox"/> Residential Treatment	<input type="checkbox"/> Urine Drug Testing # of definitive tests YTD: <input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis (WI Carve-Out) <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Court Ordered Substance Abuse Treatment (per Driver Safety Plan) <input type="checkbox"/> Other: _____	

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: Description:

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

PROVIDER INFORMATION

REQUESTING PROVIDER / FACILITY: (DECISION WILL BE FAXED TO THE REQUESTING PROVIDER/FACILITY)

Provider Name:	NPI#:	TIN#:	
Phone:	FAX:	Email:	
Address:	City:	State:	Zip:
PCP Name:	PCP Phone:		
Office Contact Name:	Office Contact Phone:		

SERVICING PROVIDER / FACILITY: (Billing Provider/Facility)

Provider/Facility Name (Required):

Billing NPI# (required):	TIN#:	Medicaid ID# (If Non-Par):	<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Phone:	FAX:	Email:	
Address:	City:	State:	Zip:
For Molina Use Only:			

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.