

# Molina Marketplace – Illinois Medical Prior Authorization Request Form

## MEMBER INFORMATION

Line of Business:	<input checked="" type="checkbox"/> Marketplace	Date of Request (MM/DD/YYYY):
State/Health Plan:	<input checked="" type="checkbox"/> Illinois	
Member Name:		DOB (MM/DD/YYYY):
Member ID:		Member Phone:
Service Type:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission <input type="checkbox"/> EPSDT/Special Services	

## REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	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 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"/> 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 START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

## PROVIDER INFORMATION

### 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:

Provider/Facility Name (Required):			
NPI:	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.

## Molina Marketplace – Illinois Behavioral Health Prior Auth Request Form

### MEMBER INFORMATION

<b>Line of Business:</b>	<input checked="" type="checkbox"/> Marketplace	<b>Date of Request (MM/DD/YYYY):</b>
<b>State/Health Plan:</b>	<input checked="" type="checkbox"/> Illinois	
<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/Expedited – Clinical Reason for Urgency <b>Required:</b> _____ <input type="checkbox"/> Emergent Inpatient Admission	

### REFERRAL/SERVICE TYPE REQUESTED

<b>Request Type:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	<b>Previous Auth:</b>
<b>Inpatient Services:</b>		<b>Outpatient Services:</b>	
<input type="checkbox"/> Inpatient Psychiatric <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  <input type="checkbox"/> Inpatient Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary  If Involuntary, Court Date: _____		<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Intensive Outpatient Program <input type="checkbox"/> Day Treatment <input type="checkbox"/> Assertive Community Treatment Program <input type="checkbox"/> Targeted Case Management  <input type="checkbox"/> Electroconvulsive Therapy <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> Applied Behavioral Analysis <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other: _____	

### PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

<b>Primary ICD-10 Code for Treatment:</b>				<b>Description:</b>	
DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

### PROVIDER INFORMATION

REQUESTING 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>PCP Name:</b>			<b>PCP Phone:</b>		
<b>Office Contact Name:</b>			<b>Office Contact Phone:</b>		
SERVICING 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>For Molina Use Only:</b>					

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.