Molina® Healthcare, Inc. – BH Prior Authorization Request Form

Providers may utilize **Molina's Provider 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 ☐ Other (Please Specify): ☐ Inpatient ER Admission (Concurrent) ☐ EPSDT/Special Services ☐ CA IPA request: Medicare Denial, requires Medicaid/LTC Review ☐ Continuity of Care (COC)		☐ Urgent (Rationale):	

REFERRAL/SERVICE TYPE REQUESTED

Line of Business:	☐ Duals	☐ 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 ☐ Other (Please Specify): ☐ Inpatient ER Admission (Concurrent)		

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ Initial Request	☐ Extension/Renewal/Amendment	☐ Previous Auth #
Inpatient Services:	**Outpatient Services:**		

☐Inpatient Psychiatric
  ☐Involuntary ☐Voluntary
 	
☐Inpatient Detoxification
  ☐Involuntary ☐Voluntary
 	
If Involuntary, Court Date:
	☐Residential Treatment
	☐Partial Hospitalization Program
	☐Intensive Outpatient Program
	☐Day Treatment
	☐Assertive Community Treatment Program
	☐Targeted Case Management
			☐Electroconvulsive Therapy
			☐Psychological/Neuropsychological Testing
			☐Applied Behavioral Analysis
			☐Non-Par Outpatient Services
			☐ Other:_____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: _____ 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.