

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

### MEMBER INFORMATION

Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Duals	<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:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – Clinical Reason for Urgency Required: _____ <input type="checkbox"/> Emergent Inpatient Admission			

### 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"/> 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

Primary ICD-10 Code for Treatment:	Description:			
Dates of Service Start	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):	
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.