

Molina® Healthcare, Inc. – BH Prior Authorization 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:	<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Other (Please Specify): <input type="checkbox"/> Inpatient ER Admission (Concurrent)			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/Renewal/Amendment	<input type="checkbox"/> 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		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):	<input type="checkbox"/> Non-Par <input type="checkbox"/> 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.