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 Review		☐ Time Sensitive (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 Start	Stop	Procedure/Services Codes	Diagnosis Code	Requested Service	Requested Units/Visits

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.