MOLINA® HEALTHCARE MEDICAID

Molina Healthcare of South Carolina, Inc. – Pre-Service Request Form

LAST UPDATED: 10/2024 PHONE: (855) 237-6178

FAX TO: **Marketplace** (833) 322-1061; **Medicaid** (866) 423-3889; **Pharmacy/J-code requests** (855) 571-3011; **MMP - Duals** (844) 251-1451; **DSNP - Complete Care** (844) 251-1450

MEMBER INFORMATION				
Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **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 ☐ Urgent/Expedited – Clinical Reason for Urgency **Required:** _____ ☐ EPSDT/Special Services			

REFERRAL / SERVICE TYPE REQUESTED			
Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient: _____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

DATES OF SERVICE START	DATES OF SERVICE 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):**	☐ **Non-Par**	☐ **COC**
Phone:	**FAX:**	**Email:**		
Address:	**City:**	**State:**	**Zip:**	

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.