

Request for Prior Authorization

Molina Complete Care is your partner in providing care.

In order to efficiently process your authorization request, fields marked with * must be completed.

Member Information:

*Full Name: _____ Height _____ Weight _____
 Address: _____
 Telephone #: (____) _____ *DOB: ____/____/____ *Medicaid #: _____
 Emergency/Legal Guardian Contact Person: _____ Telephone #: _____

Request Type: *Physical Health* ☐ *Behavioral Health* ☐
☐ Out of Network - If Out of Network, reimbursement will be at DMAS Medicaid Rates - Accept: Yes ☐ No ☐
☐ Standard/Routine

☐ Concurrent

☐ Expedited

☐ Retrospective* For inpatient medical/behavioral related to inability to verify insurance coverage timely (up to 5 days postdischarge)

* **Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Request outside of this definition should be submitted as one of the other options.**

Inpatient Services

- ☐ Surgical Procedure
- ☐ Hospitalization
- ☐ SNF
- ☐ Custodial NF
- ☐ LTACH
- ☐ Hospice (inpatient)
- ☐ Inpatient Rehabilitation
- ☐ Long Stay Hospital
- ☐ TDO/ECO

Outpatient Services

- ☐ Surgical Procedure
- ☐ Infusion Therapy
- ☐ OT/PT/ST
- ☐ Personal Care
- ☐ Respite Services
- ☐ Hospice (outpatient)
- ☐ Other _____

Additional Services

- ☐ Skilled Home Care Services
- ☐ Private Duty Nursing
- ☐ DME Purchase
- ☐ DME Rental
- ☐ J-Codes (Authorized up to 6 months at a time.)
- ☐ Other _____

*Requested Diagnosis Code: _____

*Requested CPT/HCPCS Code: _____

*Requested Number of Visits: _____ *DOS From: ____/____/____ to ____/____/____

*Frequency of Service: *(Detailed)* _____

Indicate the # of units, visits, or hours being requested daily, weekly or monthly as pertained to service requested. (i.e.:3 visits/week; 8 hrs/day).

J Code					
Drug Name/ Strength					
Dose					
Route					
Frequency					
Total Doses					

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION WITH THIS REQUEST FORM

Requesting Provider:

*Name: _____
 *Provider ID #: _____
 TIN/NPI #: _____
 Telephone #: _____
 *Fax #: _____
 *Contact Name/Phone #: _____

Servicing Provider/Facility:

*Name: _____
 *Provider ID that claim will be billed with: _____
 TIN/NPI #: _____
 Telephone #: _____
 *Fax #: _____
 *Contact Name/Phone #: _____
 *Address to mail letter: _____

Submitted By: _____ (Please Print) Date: ____/____/____

Utilization Management Department Phone: **CCC Plus:** 1-800-424-4524 or **Medallion 4.0:** 1-800-424-4518

UM CCC Plus Fax: 1-866-210-1523 or **UM Medallion 4.0 Fax:** 1-855-769-2116

Physician-Administered/HCPCS Utilization Management Department Fax: 1-844-278-5731

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