MOLINA HEALTHCARE | Molina Complete Care

Request for Prior Authorization - Outpatient Services

(Medicaid services only)

In order to efficiently process your authorization request, the information below must be completed.

Member Information:

Full Name: ____________________

Address: ____________________

Telephone #: (_____) ____________________ DOB: ___/___/_____ Medicaid #: ____________________

Primary Insurance Name (COB): ____________________

Primary Insurance ID and Effective Date: ____________________

Request Type:

- ☐ Standard/Routine
- ☐ Expedited

**** 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.***

Services

- ☐ Outpatient Surgical/Procedure
- ☐ Infusion Therapy
- ☐ Therapeutic Behavioral Services Day Program
- ☐ Hospice (outpatient)
- ☐ Psychosocial Rehabilitation Living Skills Training
- ☐ IPM/CT/MRI/MRA/CRT/ECHO/ICD/Heart Cath/PETS
- ☐ Other: _____________
- ☐ Home Care Services
- ☐ Durable Medical Equipment (DME)
- ☐ Prosthetic/Orthotic
- ☐ Enterals/Nutritional/Metabolic Foods
- ☐ Residential
- ☐ Chiropractor <21 years of age

Please use the ABA, Synagis and specialty medication prior authorization forms

Diagnosis Code and Description: ____________________

CPT/HCPCS Code and Description: ____________________

Number of Visits Requested: ____________________ DOS From: ___/___/____ To: ___/___/____

Please send clinical notes and all supporting documentation

Requesting Provider:

Name: ____________________

NPI #: _______________ TIN#: _______________

AHCCCS ID: ____________________

Telephone #: ____________________

Address: ____________________

Fax #: ____________________

Contact Name/Phone #: ____________________

Servicing Provider:

Name: ____________________

NPI #: _______________ TIN#: _______________

AHCCCS ID: ____________________

Telephone #: ____________________

Address: ____________________

Fax #: ____________________

Contact Name/Phone #: ____________________

Submitted By: ______________________________ Date: ___/____/___ Phone Number: _____________

(Please Print)

Please submit all supporting documentation and any applicable information with this request form

Utilization management department phone number: (800) 424-5891

Outpatient utilization management fax number: (888) 656-7501

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