MOLINA HEALTHCARE | Molina Complete Care

Request for Prior Authorization- Specialty Medications

(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: _____

Requested Diagnosis Code: _____

_____

Requested J, S or Q/ HCPCS Code: _____

Requested Number of Units: _____ DOS From: _____/_____/_____ to _____/_____/_____

Please use the Synagis specific prior authorization form for these specific requests

Please send clinical notes and all supporting documentation

Requesting Provider:	**Servicing Provider/Facility:**
Name: _____	Name: _____
NPI #: _____TIN#: _____	NPI #: _____TIN#: _____
AHCCCS ID: _____	AHCCCS ID: _____
Telephone #: _____	Telephone #: _____
Address: _____	Address: _____
Fax #: _____	Fax #: _____
Contact Name/Phone #: _____	Contact Name/Phone #: _____

Submitted By: _____ Date: _____/____ /_____

(Please Print)

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

Utilization Management phone number: (800) 424-5891

Specialty Medication fax number: (888) 656-6101