Molina Healthcare of Michigan
Prior Authorization Request Form

Phone Number: (888) 898-7969
Medicaid Fax Number: (800) 594-7404
Medicare Fax: (888) 295-7665

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina MI Child** ☐ **Molina Medicare** ☐ **Other:**_____

Member Name:_____ DOB: _____

Member ID# :_____ Member Phone # : ___(_____)_____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

*** Definition of Urgent / 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. Requests outside of this definition should be submitted as routine/ non-urgent.**

Referral/ Service Type Requested		
Inpatient ☐ Surgical Procedures ☐ ED Admission ☐ Direct Admission ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Rehab (PT, OT, & ST) ☐ Diagnostic Procedure ☐ Imaging ☐ Chiropractic ☐ Wound Care ☐ Infusion Therapy	☐ **DME** ☐ **Home Health** ☐ **In Office**

Referred To Provider/Facility Name & Tax ID# : _____

Referred To Address & Phone# : _____

Diagnosis Code & Description:_____

CPT/HCPCS Code & Description:_____

Number of visits requested:_____ Date(s) of Service:_____

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name and Address:_____

Contact @ Requesting Provider's: _____

Phone Number: _(_____)_____Fax Number: _(_____)_____

For Molina Use Only: