Molina Healthcare Prior Authorization Request Form

Phone Number: 1-866-449-6849 (Bexar, Harris, Dallas, Jefferson, El Paso & Hidalgo Service Areas)
1-877-319-6826 (CHIP Rural Service Area)
Fax Number: 1-866-420-3639

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **TANF** ☐ **Other**

Member's Name: _____ DOB: _____

Member's ID#: _____ Member Phone #: _____

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

***Definition of expedited/urgent is when the situation where the standard time frame or decision making process (up to 14 days per Molina's process) could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.**

Referral/Service Type Requested

Inpatient	**Outpatient**	
☐ Surgical procedures	☐ Surgical Procedure	☐ **Home Health**
☐ ER Admits	☐ Rehab (PT, OT, & ST)	
☐ SNF	☐ Diagnostic Procedure	☐ **DME**
☐ Rehab	☐ Chiropractic	
☐ LTAC	☐ Wound Care	☐ **In Office**
	☐ Infusion Therapy	

Diagnosis Code & Description: _____

CPT/HCPC Code & Description: _____

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

Please send clinical notes and any supporting documentation

Provider Information

Requesting Provider Name: _____

Facility Providing Service: _____

Contact @ Requesting Provider's: _____

Phone Number: _____ Fax Number: _____

For Molina Use Only: