Molina Healthcare of Illinois Medical Prior Authorization Request Form For Medicaid and MMP/Dual Options Plans

MMP/Medicaid Phone: **(855) 866-5462**	Medicaid Fax: **(866) 617-4971**	MMP - Inpatient Fax: **(844) 834-2152** MMP - Outpatient Fax: **(844) 251-1451**	Non-Emergent Transportation: MTM Phone: **(844) 644-6354** MTM: Fax **(877) 406-0658**	Imaging & Special Testing: Fax: **(877) 731-7218**	Radiation, Sleep, Molecular Tests: Medicaid Fax: **(877) 731-7218** MMP Fax: **(844) 251-1451**	NICU Faxes: Medicaid **(888) 817-3624** MMP **(866) 617-4971**	Transplant Fax: **(877) 813-1206**

Member Information			
Plan:	☐ Molina Medicaid	☐ Molina Dual Options (Medicaid/Medicare)	
Member Name:		DOB:	**Today's Date**:
Member ID:		Member Phone Number:	
Service Type:	☐ Elective/Routine Determination within **four (4) calendar days** from receipt of all necessary information.	☐ Expedited/Urgent I certify the request is urgent and medically necessary to treat an injury, illness or condition (not life-threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.	

***** Clinical notes and supporting documentation are REQUIRED to review for medical necessity.*****

Referral/Service Type Requested			
☐ **Repeat request/PA expired**		☐ **Previous Authorization No.:**	
Inpatient: ☐ ER Admits ☐ SNF ☐ LTAC ☐ Custodial ☐ Acute Inpatient Rehab ☐ Inpatient Detox ☐ Ventilator Services	****Outpatient:** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy	****Office:** ☐ Office Procedure/Visit **** Home Health:** ☐ Skilled Services ☐ Home Infusion	**** DME** ☐ Wheelchair (Purchase/Repair) ☐ Enteral Formula/Supplies ☐ Prosthetic/Orthotic ☐ Other ☐ **Out-of-State request**

Procedure Information			
*Diagnosis Code & Description:			**For Molina Healthcare use only:**
*CPT/HCPC Code & Description:			
*J Code/Description/Dose/NDC:			
***Number of visits/days/units requested (circle type and specify quantity):**			
Dates of Service:	**From:**	**To:**	

Requesting Provider Information		
*Name/Credentials:		IL Medicaid Certified ☐Yes ☐No
*Address:		Contact Name:
*Billing NPI:	*Phone No.: ( )	*Fax No.: ( )
*Billing TIN:		

Servicing Provider / Facility Information		
*Name:		IL Medicaid Certified ☐Yes ☐No
*Address:		Contact Name:
*Servicing NPI:	*Phone No.: ( )	*Fax No.: ( )
*Servicing TIN:		

***ALL REQUIRED FIELDS—MUST BE COMPLETED. INCOMPLETE FORMS WILL BE REJECTED.**

*****PA NOT REQUIRED FOR PLANNED ADMISSIONS. PLEASE NOTIFY MOLINA UPON ADMISSION.*****

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per plan policy and procedures.

Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

By requesting prior authorization, the provider is affirming that the services are medically necessary; a covered benefit under the Medicare and/or Medicaid Program(s), and the servicing provider is enrolled in those programs as eligible for reimbursement. As a condition of authorization, for services that are primary to Medicare, the out-of-network provider agrees to accept no more than 100 percent of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forth by CMS in effect on the Date(s) of Service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including but not limited to co -payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member was enrolled in the Medicare Fee-For-Service Program. If the service is primary to Medicaid, the out-of-network agrees to accept no more than the amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of Illinois in effect on the Date(s) of Service, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Molina Healthcare will not reimburse providers for services that are not deemed medically necessary. Servicing providers also recognize that Molina Healthcare members are not to be balanced billed for any uncollected monies for covered services pursuant to Medicare and Medicaid billing guidelines.