MOLINA HEALTHCARE | Molina Complete Care

Request for Prior Authorization – Inpatient Services

(Medicaid services only)

In order to efficiently process your 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:

☐ Concurrent

☐ Retrospective

Inpatient Services

☐ Hospitalization - notification of admission Admit Time: _____

☐ Skilled Nursing Facility

☐ LTAC

☐ Hospice

☐ Inpatient rehabilitation

☐ IMD

Other: _____

Diagnosis Code and Description: _____

CPT/HCPCS Code and Description: _____

Number of Days Requested: _____ DOS From: ____/____/____ To: ____/____/____

Please send clinical notes and all supporting documentation

Requesting Provider:

Name: _____

NPI #: _____TIN#: _____

AHCCCS ID: _____

Address: _____

Telephone #: _____

Fax #: _____

Contact Name/Phone #: _____

Servicing Provider:

Name: _____

NPI #: _____TIN#:_____

AHCCCS ID: _____

Address: _____

Telephone #: _____

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

Inpatient utilization management department fax number: (888) 656-2201