![Molina Healthcare logo]

Asthma Remediation is a Community Supports (CS) that can assist members by identifying, coordinating, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the member or to enable the member to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization.

This referral must be signed off by a licensed health care professional. The submission of this referral is an attestation that Asthma Remediation services will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.
Send the completed referral via secure Prior Auth Fax: (800) 811-4804.

Eligibility Criteria:
Molina Enrollment: ☐ Medi-Cal with Molina
Member must meet one of the two (2) following criteria:
☐ Member had an emergency department visit or hospitalization OR two PCP or urgent care visits in the past 12 months due to asthma-related complications.
☐ Member scored 19 or lower on an Asthma Control Test. Attach scored test results.
☐ Member is not receiving duplicative support from other State, local, or federally funded programs.
☐ Member consented to Asthma Remediation referral and acknowledges once in a lifetime restriction.

Licensed Health Care Professional:	
Name:	Credentials:
Hospital/SNF/Clinic/Office/FQHC Name:	
Professional License Number:	
Signature:	Date:

Requestor Information:	
Last Member Contact:	
Referrer: ☐ Hospital/SNF ☐ PCP/Clinic ☐ IPA ☐ ECM ☐ Molina CM ☐ Other:	
Referrer Organization Name:	
Referrer Name:	Title:
Referrer Phone Number:	Fax Number:

Member Information:	
Member Name:	DOB:
Medi-Cal ID:	Preferred Language:
Home Address:	
City:	State:	Zip Code:
Home Phone #:	Cell Phone #:
Alternate Contact Name:	Phone #:

If member has previously received Asthma Remediation Community Supports services, please include information explaining how the member's condition has changed so significantly that additional modifications are necessary.