



**Molina Healthcare of California**

COMMUNITY BASED ADULT SERVICES (CBAS) REQUEST FOR SERVICES

*Please fax completed form to: Molina Healthcare of California CBAS at 1-800-811-4804, if you have questions may call our Molina Utilization Management Department 1-800-526-8196 Ext. 126400*

<b>DATE:</b>		<b>PCP:</b>		
<b>REFERRING PHYSICIAN INFORMATION</b>				
<b>REFERRING PHYSICIAN:</b>		<b>REFERRING PHYSICIAN NPI NUMBER:</b>		<b>REFERRING PHYSICIAN PHONE NUMBER:</b>
<b>REFERRING PHYSICIAN ADDRESS:</b>				<b>REFERRING PHYSICIAN FAX NUMBER:</b>
<b>PATIENT INFORMATION</b>				
<b>MEMBER NAME:</b>	<b>GENDER:</b>	<b>DOB:</b>	<b>AGE:</b>	<b>MEMBER ID (Medi-Cal/CIN):</b>
<b>ADDRESS:</b>		<b>PHONE NUMBER:</b>		<b>ALTERNATE NUMBER:</b>
<b>PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) Enter Name and Address</b>			<b>Preferred Language:</b>	
<b>REFERRAL - SERVICE TYPE REQUESTED</b>				
<input type="checkbox"/> Expedited Referral for Post Hospitalization/SNF stay		<input type="checkbox"/> Initial CBAS Services		<input type="checkbox"/> Modification of Days for IPC
		<input type="checkbox"/> Continued CBAS Services for 6 months (Must include IPC & Last TAR Number)		
<b>CBAS CENTER SUBMITTING THIS REQUEST</b>				
<b>PROVIDER NAME or Specify DBA:</b>		<b>PROVIDER NPI NUMBER:</b>		<b>PHONE NUMBER:</b>
<b>ADDRESS:</b>				<b>FAX NUMBER:</b>
<b>DIAGNOSIS/PROCEDURE INFORMATION</b>				
<b>ICD-10 CODE(S) /DESCRIPTION:</b>		<b>CPT CODE(S)/DESCRIPTION:</b>		<b>HCPCS /DESCRIPTION:</b>
<b>MEDICAL JUSTIFICATION – Include pertinent information regarding IPC (i.e. past medical treatment, physical findings and attach all relevant medical records, test results, etc.):</b>				
<b>DATES AND SPECIFIC SERVICES REQUESTED</b>		<b>DAY'S PER WEEK</b>		<b>QUANTITY/UNITS</b>
<b>REQUESTING PROVIDER (PRINT):</b>		<b>SIGNATURE:</b>		<b>DATE:</b>
<b>Criteria/guidelines Met:</b> <input type="checkbox"/> yes <input type="checkbox"/> no		<b>Authorization Status:</b> <input type="checkbox"/> approved <input type="checkbox"/> modified <input type="checkbox"/> deferred <input type="checkbox"/> denied		<b>Authorization Number:</b>
<b>Comments:</b>				

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**THIS REFERRAL IS VALID FOR 30 DAYS ONLY**

Form Revised: 04.22.2022