MOLINA HEALTHCARE

Molina Healthcare of Illinois Behavioral Health Prior Authorization Request Form

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**

Member Information			
Illinois LOB	☐ Molina Medicaid	☐ Molina MMP Dual Options	☐ Molina Marketplace
Member Name:		DOB:	**Today's Date**:
Member ID:		Member Phone Number:	
Service Type	☐ Non-Urgent/Elective/Routine Determination within **four (4) calendar days** from receipt of all necessary information. ☐ Emergent Inpatient Admission	☐ Expedited/Urgent Clinical Reason: _____ 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.	

*** Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the Member's health or could jeopardize the Member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent**

Referral/Service Type Requested		
Request Type	☐ Initial Request/New Admission	☐ Extension/Renewal/Concurrent Auth No.:

Inpatient Services	Outpatient Services	
☐ Inpatient Psychiatric: ☐ Voluntary ☐ Involuntary	☐ Partial Hospitalization Program	☐ Electroconvulsive Therapy
☐ Inpatient Detox, BH Unit	☐ Intensive Outpatient Program	☐ Psychological/Neuropsychological Testing
☐ Residential Treatment (ASAM 3.5)	☐ Day Treatment	☐ Applied Behavioral Analysis
☐ Subacute Detoxification (ASAM 3.7)	☐ Assertive Community Treatment Program	☐ Non-PAR Outpatient Services
	☐ Targeted Case Management	☐ Other:

***** Clinical notes and supporting documentation are <u>required</u> to review for medical necessity. *****

Primary ICD-10 Code for Treatment, With Description					
Dates of Service Start	Stop	Procedure/Service Codes	Diagnosis Code	Requested Service	Requested Units/Visits

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

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

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

For Molina Use Only:

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must bea 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. Ifyou 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% of an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) set forthby 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.