Senior Whole Health
BY MOLINA HEALTHCARE

Medicare Medical
Prior Authorization Request Form

COMPLETE ALL SECTIONS OF THIS FORM AND FAX IT TO 1-855-818-4871.
INCOMPLETE SUBMISSIONS MAY BE RETURNED UNPROCESSED.

Senior Whole Health of New York		
Fax:	**Date Form Completed/Faxed:**	
Authorization Type		
☐ **In-Network** ☐ **Out of Network**	**Urgency:** ☐ **Expedited*** ☐ **Standard** ☐ **Concurrent** ☐ **Retrospective** * Please request "expedited" when applying the standard timeframe for making the determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.	
Service Type Requiring Authorization (check all that apply)		
Ambulatory/Outpatient Services ☐ Surgery/Procedure (SDC) ☐ Infusion or Oncology Drugs	**Ancillary** ☐ Acupuncture ☐ Chiropractic ☐ IVF/ART ☐ Non-Participating Specialist	**Dental** ☐ Adjunctive Dental Services ☐ Endodontics ☐ Maxillofacial Prosthetics ☐ Oral Surgery ☐ Restorative
Durable Medical Equipment ☐ Prosthetic Device ☐ Purchase ☐ Renal Supplies ☐ Rental	**Home Health/Hospice** ☐ Home Health (Please circle: SN, PT, OT, ST, HHA, MSW) ☐ Hospice ☐ Infusion Therapy ☐ Respite Care	**Inpatient Care/Observation** ☐ Acute Medical/Surgical ☐ Long-term Acute Care ☐ Acute Rehab ☐ Observation **Skilled Nursing Facility (Select level):** ☐ LTC ☐ Level I ☐ Level II ☐ Level III
Nutrition/Counseling ☐ Counseling ☐ Enteral Nutrition ☐ Infant Formula ☐ Total Parental Nutrition	**Outpatient Therapy** ☐ Occupational Therapy ☐ Physical Therapy ☐ Pulmonary/Cardiac Rehab ☐ Speech Therapy	**Transportation** ☐ Non-emergent Ground ☐ Non-emergent Air
Other—please specify:		
Provider Information *(*Denotes required field)*		
***Requesting Provider Name/NPI#:**	***Phone:**	**Fax:**
***Servicing Provider Name/NPI# (and Tax ID if required):** ☐ *Same as Requesting Provider*	***Phone:**	**Fax:**
***Contact Person:**	***Phone:**	**Fax:**

Member Information *(*Denotes required field)*		
***Patient Name:**	***☐ Male ☐ Female**	***DOB: (MM/DD/YYYY)**
Health Insurance ID#:** ***If other insurance, please specify:		***Patient Account/Control Number:**
Address:		**Phone:**
Diagnosis/Planned Procedure Information (*Denotes required field)		
***Principal Diagnosis Description:** **ICD-10 Codes:**	***Principal Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** **☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage**	
Secondary Diagnosis Description: **ICD-10 Codes:**	**Secondary Planned Procedure (Description and CPT/HCPCS Code):** **# of Units Being Requested:** **☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage**	
***Service Start Date:**	***Service End Date:**	

****Confidentiality Notice****

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