Molina® Healthcare, Inc. – Prior Authorization Request Form

MOLINA® HEALTHCARE MEDICARE
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 01/01/2022

FOR DUAL MEMBERS WITH MEDICAID, PLEASE REFER TO YOUR STATE MEDICAID PA GUIDE FOR ADDITIONAL PA REQUIREMENTS

REFER TO MOLINA'S PROVIDER WEBSITE OR PRIOR AUTHORIZATION LOOK-UP TOOL/MATRIX FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING PRIMARY CARE PROVIDERS DO NOT REQUIRE PA.
OFFICE VISITS TO NETWORK SPECIALISTS DO NOT REQUIRE A REFERRAL FROM A PARTICIPATING PRIMARY CARE PROVIDER
EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:** ○ Inpatient, Partial hospitalization; ○ Electroconvulsive Therapy (ECT).
- **Chiropractic Care**
- **Cosmetic, Plastic and Reconstructive Procedures**: No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment and Medical Supplies**
- **Elective Inpatient Admissions:** Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**
- **Healthcare Administered drugs**
  - For Medicare Part B drug provider administered drug therapies, please direct Prior Authorization requests to Novologix via the Molina Provider Portal. You may also fax in a prior authorization at 800-391-6437.
- **Hearing Aides**
  - Benefit is only available from HearUSA participating providers. Hearing aids require prior authorization
- **Home Healthcare Services (including homebased PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** Not a Medicare covered benefit*. **(*Per State benefit if MMP)**

  Miscellaneous & Unlisted Codes: Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.

- **Neuropsychological and Psychological Testing**
- **Non-Par Providers/Facilities:** PA is required for office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency and Urgently needed Services; ○ Professional fees associated with ER visits and approved Ambulatory Surgery Center (ASC) or inpatient stays;
  - Dialysis when temporarily absent from service area. ○ Ambulance services dispatched through 911 ○ PA is waived for all radiologists, anesthesiologists, and pathologists' professional services when billed for POS 19, 21, 22, 23 or 24
  - PA is waived for professional component services or services billed with Modifier 26 in ANY place of service setting.
- **Occupational, Physical, & Speech Therapy**: PA required after Medicare therapy benefit threshold ($2,110 for PT & ST combined and $2,110 for OT) has been reached for office and outpatient settings. • **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures including acupuncture**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery**
- **Sleep Studies**
- **Supervised Exercise Therapy (SET)**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Transportation Services:** non-emergent air transportation.

Molina® Healthcare, Inc. – Prior Authorization Request Form

IMPORTANT INFORMATION FOR MOLINA HEALTHCARE MEDICARE PROVIDERS

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab or X-ray report/results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician.

IMPORTANT MOLINA HEALTHCARE MEDICARE CONTACT INFORMATION	
NY SCO (Service Hours: 8am to 5pm local time Monday to Friday, unless otherwise specified)	
In-patient (IP) Prior Authorizations (includes Behavioral Health): **Phone:** (800) 526-8196 **Fax:** 844-834-2152	**Pharmacy Authorizations:** **Phone:** (800) 665-3086 **Fax:** (866) 290-1309
Out-patient (OP) Prior Authorizations (includes Behavioral Health): **Phone:** (855) 322-4075 **NY MAP Fax:** (844) 251-1451 **MLTC Services:** 1-855-818-4871	**Provider Customer Service:** **Phone:** 877-635-3101 and 877-353-9819
Radiology Authorizations: **Phone:** (855) 714-2415 **Fax:** (877) 731-7218	**Dental (DentaQuest):** **Phone:** (855) 343-4272 TTY 711 **Website**: https://www.dentaquest.com/
Transplant Authorizations: **Phone:** (855) 714-2415 **Fax:** (877) 813-1206	**Hearing (HearUSA):** **Phone:** (800) 442-8231 **Website:** https://www.hearusa.com/
Member Customer Service, Benefits/Eligibility: **NY SCO:** (833) 671-0440 TTY: 711	**Vision (VSP):** Phone: (855) 492 -9028 TTY (800) 428-4830 Website:WWW.VSP.COM
Nurse Advice Line: (7 days/week) **No referral or prior authorization is needed.** **Phone:** (888) 275-8750 (TTY: 711) Members who speak Spanish can press 1 at the IVR prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members.	**Transportation NY** **Phone:** (855)-558-1638 TTY (866)-288-3133 **Reservation: Ride Assist (Where's My Ride):** 877-718-4220 **Facility line:** (866) 428-2351
Meals (Home delivered Meals): **Phone:** (833)671-0440 – Case Managers	
Providers may utilize Molina Healthcare's Website at: https://provider.molinahealthcare.com/Provider/Login Available features include: • **Authorization submission and status** • **Claims submission and status** • **Member Eligibility** • **Download Frequently used forms** • **Provider Directory** • **Nurse Advice Line Report**	

Molina® Healthcare, Inc. – Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. CA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Other (Please Specify): _____ ☐ Inpatient ER Admission (Concurrent) ☐ EPSDT/Special Services		☐ Time Sensitive (Rationale): _____	

Commented [WS1]: Forces provider to write urgent/expedited and why for OCR

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**		
☐ Inpatient Hospital	☐ Chiropractic	☐ Office Procedures	☐ Pharmacy
☐ Inpatient Transplant	☐ Dialysis	☐ Infusion Therapy	☐ Physical Therapy
☐ Inpatient Hospice	☐ DME	☐ Laboratory Services	☐ Radiation Therapy
☐ Long Term Acute Care (LTAC)	☐ Genetic Testing	☐ LTSS Services	☐ Speech Therapy
☐ Acute Inpatient Rehabilitation (AIR)	☐ Home Health	☐ Occupational Therapy	☐ Transplant/Gene Therapy
☐ Skilled Nursing Facility (SNF)	☐ Hospice	☐ Outpatient Surgical/Procedures	☐ Transportation
☐ Other Inpatient: _____	☐ Hyperbaric Therapy	☐ Pain Management	☐ Wound Care
	☐ Imaging/Special Tests	☐ Palliative Care	☐ Other:

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code: **Description:**

DATES OF SERVICE START	DATES OF SERVICE STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

REQUESTING / REFERRING PROVIDER / FACILITY:

Provider Name:		**NPI#:**	**TIN#:**	
Phone:	**FAX**:		**Email**:	
Address:		**City:**	**State:**	**Zip:**
PCP Name:		**PCP Phone**:		
Office Contact Name:		**Office Contact Phone**:		

SERVICING / BILLING PROVIDER / FACILITY:

Provider/Facility Name (Required):				
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par**	☐**COC**
Phone:	**FAX:**		**Email:**	
Address:		**City:**	**State:**	**Zip:**

For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.

Molina® Healthcare, Inc. – BH Prior Authorization Request Form

MEMBER INFORMATION

Line of Business:	☐ **Medicaid**	☐ **Marketplace**	☐ **Medicare**	**Date of Request:**
State/Health Plan (i.e. CA):				
Member Name:			**DOB** (MM/DD/YYYY):	
Member ID#:			**Member Phone**:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Other (Please Specify): _____ ☐ Inpatient ER Admission (Concurrent)			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ **Initial Request**	☐ **Extension/ Renewal / Amendment**	**Previous Auth#:**

Inpatient Services:	**Outpatient Services:**	
☐ Inpatient Psychiatric ☐Involuntary ☐Voluntary ☐ Inpatient Detoxification ☐Involuntary ☐Voluntary If Involuntary, Court Date:_____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management	☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment: **Description:**

DATES OF SERVICE START	DATES OF SERVICE STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS

PROVIDER INFORMATION

REQUESTING / REFERRING PROVIDER / FACILITY:

Provider Name:		**NPI#:**	**TIN#:**
Phone:	**FAX**:	**Email**:	
Address:	**City:**	**State:**	**Zip:**
PCP Name:		**PCP Phone**:	
Office Contact Name:		**Office Contact Phone**:	

SERVICING / BILLING PROVIDER / FACILITY:

Provider/Facility Name (Required):			
NPI#:	**TIN#:**	**Medicaid ID# (If Non-Par):**	☐**Non-Par** ☐**COC**
Phone:	**FAX:**	**Email:**	
Address:	**City:**	**State:**	**Zip:**

For Molina Use Only:

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions and other applicable standards during the claim review, including the terms of any applicable provider agreement.