Molina Healthcare of New York
Behavioral Health Prior Authorization Form
Phone Number: 1-800-223-7242
Fax Number: 1-866-879-4742

Member Information

Plan: ☐ Medicaid ☐ Essential HP ☐ CHP Date of Request: _____ Admit Date: _____
Request Type: ☐ **Initial** ☐ **Concurrent**
Member Name: _____ Member DOB: _____

Member ID#: _____ Member Phone #: (_____)_____

Provider Information

Treatment Provider/Facility/Clinic Name: _____
Address: _____
NPI#: _____ TIN: _____
Attending Psychiatrist Name: _____
UR Contact Name: _____UR Phone #: (_____)_____UR Fax #: (_____)_____
Provider Status: ☐ PAR ☐ Non-PAR
Member Court Ordered? ☐ Yes ☐ No ☐ In Process Court Date_____

Service Type Requested

Service is for: ☐ Mental Health ☐ Substance Use ICD-10 Diagnosis: CPT Code Requested: Dates of Service Requested:

☐ Inpatient Psychiatric Hospitalization ☐ Involuntary ☐ Voluntary ☐ Partial Hospitalization Program ☐ *PROS (Personalized Recovery Oriented Services) ☐ *ACT (Assertive Community Treatment)	☐ Detoxification ☐ Inpatient Rehabilitation ☐ Stabilization Services in a Residential Setting ☐ Rehabilitative Services in a Residential Setting ☐ Voluntary ☐ Involuntary **(Court Order Must Be Attached)** ****PAR providers must use State designated 48-hour notification form**	☐ Psychological/Neuropsychological Testing ☐ Electroconvulsive Therapy (ECT) ☐ Applied Behavior Analysis ☐ Non-PAR Services: ☐ Other (Describe):

*** PROS and ACT Providers Please Use Treatment Specific Form**
***** Clinical Documentation Must Be Attached**

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