MEDICARE

7050 Union Park Center Drive
Suite 200
Midvale, Utah 84047

PHARMACY DEPARTMENT

800-665-3086 PHONE

800-391-6437 FAX

TO:	FROM:
COMPANY:	DATE:
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER:	SENDER'S PHONE NUMBER:

FAX COVER SHEET

Please fax back completed form to 800-391-6437 to ensure a prompt review. Thank you

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

Providers may utilize Molina Healthcare's websites:

Log In to Availity®
- **Claims Submission and Status**
- **Authorization submission and Status**
- **Member Eligibility**

Home (sapphirethreesixtyfive.com)
- **Download Frequently Used Forms**
- **Provider Directory**

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):________________________

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 (LTAC)	☐Genetic Testing	☐LTSS Services	☐Speech Therapy
☐Acute Inpatient Rehabilitation (AIR)	☐Home Health	☐Occupational Therapy	☐Transplant/Gene Therapy
☐Skilled Nursing (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	Stop	Procedure/Services 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.