Provider Bulletin

Central Health Medicare Plan

September 17, 2025

☒ Alameda ☒Contra Costa ☒ Fresno ☒ Imperial ☒ Kern ☒ Kings ☒ Los Angeles ☒ Madera ☒ Orange
☒ Placer ☒ Riverside ☒ Sacramento ☒ San Bernardino ☒ San Diego ☒ San Francisco ☒ San Joaquin
☒ San Mateo ☒ Santa Clara ☒ Solano ☒ Stanislaus ☒ Tulare ☒ Ventura ☒ Yolo

Changes to Prior Authorization for John Muir Health Network

This is an advisory notification to Central Health Medicare Plan (CHP) network providers applicable to CHP Medicare business.

What you need to know:

Dear Providers,

Please see the attached communication outlining updates to the prior authorization process. Starting October 1, 2025, prior authorization requests for select services will be submitted to CHP/Molina's Utilization Management Department.

Note: This is only impacting members that were previously delegated to John Muir Health Network. It will not impact members assigned to other IPAs.

When this is happening:

Effective October 1, 2025.

Provider Action

Register and submit prior authorization requests via Availity provider portal at provider.molinahealthcare.com/.

Use the Prior Authorization Lookup Tool available on the CHP website: centralhealthplan.com/chp/Providers/Provider-Materials.aspx

What if you need assistance?

If you have any questions regarding the notification, please contact your CHP Provider Relations Representative at PRCalifornia@molinahealthcare.com.

September 15, 2025

Dear Provider,

We are writing to inform you of some upcoming changes to the prior authorization process in collaboration with John Muir Health Network and CHP. Effective October 1st, 2025, prior authorization for the following services should be submitted to Central Health Plan's/Molina Health Care's Utilization Management Department:

- Facility-based services (ASC, hospital outpatient, hospital inpatient) services, including:
    - *Lithotripsy and Endoscopy Studies*
    - *Diagnostic Service/Treatment- Invasive*
    - *Mental health services*
    - *Hyperbaric oxygen therapy*
    - *Radiation therapy*
    - *Surgeries, including oral, reconstructive, and cosmetic*
    - *Nuclear Medicine Diagnostics/Therapy (including technical in an office setting)*
    - *Infusion Therapy*
    - *Detoxification*
    - *Chemical Dependency Rehabilitation*
    - *Chemotherapy (Including Part B drugs)*
    - *Rehabilitation Services*
    - *Surgical Supplies*

- Allergy Serum
- Transfusion services, including autologous blood
- Transplants & CAR-T therapy – initial evaluation & listing, transplant, 1-year post-transplant
- Ambulance (Emergency and Transfers Out-of-Area)
- Breast Implants (Facility & Implant)
- Chemotherapy Part B Drugs -Outpatient & Inpatient Facility
- Contact Lenses (Surgical Prostheses)
- Corrective Appliances
- Diagnostic Service/treatment (Inpatient facility)
- Diabetes Supplies (Home Glucose Monitoring Equipment)
- Durable Medical Equipment (DME)
- Prosthetic Devices, including Artificial Limbs
- Orthotics
- Ostomy Supplies
- Colostomy Supplies (Outpatient dispensing, Home Health & Inpatient dispensing)
- Genetic Testing
- Home Health
- Extended Care/Skilled Nursing (Facility)
- Skilled Nursing Facilities (Facility)
- Hemodialysis (Inpatient and Outpatient Facility)

- Laboratory Services (Inpatient)
- Injectable Medications (Outpatient, self-administered and non-self-administered): Injectable, infused drugs, biologicals, and medications
- Preadmission testing
- Palliative Care (Facility)
- Physical therapy (Inpatient)
- Radiology Services Diagnostic (Inpatient)
- Diagnostic Services & Treatment (Inpatient Facility)
- Wound Care & Supplies (Part B)

Please continue to submit requests for the following services to the appropriate vendor:

- Hearing aids
- Routine transportation, including a gurney or a wheelchair
- Vision – Screening, refraction, corrective frames & lenses

You can register for access and submit authorization requests via our authorization portal at https://provider.molinahealthcare.com/. You can also find a list of services that do not require authorization if they are included in the above list: Prior Authorization Lookup Tool
Our prior authorization form is also available at this site and can be faxed to the following departments:

In-patient (IP) (Includes Behavioral Health Authorizations)
Phone: (800) 665-3086 Fax: (844) 834-2152 Peer to Peer: (866) 425-0786

For all Post-Acute requests (SNF, LTAC, Acute Rehab)
Phone: (800) 665-3086 Fax to: (833)912-4454 Peer to Peer: (866) 425-0786

Prior Authorizations (Includes Planned Inpatient and Behavioral Health)
Authorizations Phone: (800) 665-3086 Medicare Fax: (844) 251-1450 MMP/FIDE/CA EAE Fax: (844) 251-1451 Peer to Peer: (866) 425-0786

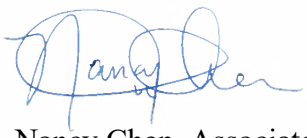
Pharmacy Authorizations Part D
Phone: (800) 665-3086 Fax: (866) 290-1309

Part B Healthcare Administered Drugs
Fax: (800) 391-6437

Advance Imaging Authorizations
Phone: (855) 714-2415 Fax: (877) 731-7218

Transplant Authorizations
Phone: (855) 714-2415 Fax: (877) 813-1206

Thank you,



Nancy Chen, Associated Vice President Network Management & Operations

CENTRAL HEALTH MEDICARE PLAN

Molina® Healthcare, Inc. – Prior Authorization Request Form

Providers may utilize Molina's Provider Portal:

- **Claims Submission and Status**
- **Authorization Submission and Status**
- **Member Eligibility**

MEMBER INFORMATION

Line of Business:	☐ **Duals**	☐ **Medicare**	☐**CA EAE (Medicaid)**	**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 ☐ Urgent ☐ Inpatient ER Admission (Concurrent) ☐ EPSDT/Special Services ☐ CA IPA request: Medicare Denial, requires Medicaid/LTC Review		☐ Continuity of Care (COC)	

REFERRAL/SERVICE TYPE REQUESTED

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

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

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.

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
7050 Union Park Center Drive Suite 600
Midvale, Utah 84047

Fax Number:
(866) 290-1309

You may also ask us for a coverage determination by phone at (800) 665-3086 or through our websites at MolinaHealthcare.com/Medicare, SWHMA.com, SWHNY.com, mychoicewi.org or centralhealthplan.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*****

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*****

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*****

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*****

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider *(attach any supporting documents)*:

_____

_____

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_____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐**CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:	**Date:**

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐**REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: ☐ **NEW START**	Expected Length of Therapy:	Quantity per 30 days
Height/Weight:	Drug Allergies:	
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)		**ICD-10 Code(s)**
Other RELAVENT DIAGNOSES:		**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)		
DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY		
Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?	☐ **YES**	☐ **NO**
Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the enrollee's current drug regimen?	☐ **YES**	☐ **NO**
If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety		
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY		
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?	☐ **YES**	☐ **NO**
OPIOIDS – (please complete the following questions if the requested drug is an opioid)		
What is the daily cumulative Morphine Equivalent Dose **(MED)**?		**mg/day**
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	☐ **YES**	☐ **NO**
Is the stated daily MED dose noted medically necessary?	☐ **YES**	☐ **NO**
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ **YES**	☐ **NO**
RATIONALE FOR REQUEST		

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐ **Request for formulary tier exception** Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐ **Other** (explain below)

Required Explanation _____

_____

_____

_____

_____

_____

Molina Healthcare is a C-SNP, D-SNP and HMO plan with a Medicare contract. D-SNP plans have a contract with the state Medicaid program. Enrollment depends on contract renewal.

VA D-SNP Only: Molina Healthcare is a D-SNP with a Medicare contract. D-SNP plans have a contract with the Virginia Department of Medical Assistance Services' Cardinal Care Medicaid program. Enrollment depends on contract renewal.

CHP Only: Central Health Medicare Plan is an HMO/HMO SNP with a Medicare contract. Enrollment in Central Health Medicare Plan depends on contract renewal.

NM D-SNP Only: Such services are funded in part with the State of New Mexico.

https://www.molinahealthcare.com/members/common/en-US/multi-language-taglines.aspx

https://centralhealthplan.com/Docs/Member/Multi_Lanugage_Insert.pdf