Instructions for Submitting Service Request Forms

Services Requiring Authorization

The following list includes all services that require prior authorization. Any services not on this list and performed by a participating provider DO NOT require prior authorization. For your convenience, a list of procedure codes that require prior authorization can be found at **www.MolinaHealthcare.com** by selecting the *Resource* tab and *Service Request Resources* link. To request a hardcopy of this list, please call **(800) 642-4168.**

Services Requiring Prior Authorization

- Ambulatory surgical services
  - Cosmetic/Plastic procedures
  - Dermatologic procedures
  - ENT – except T & A and Myringotomy
  - Oral Maxillofacial procedures
  - Pain Management procedures, including all injections
  - Reductive Mammoplasty
  - Uvulopalatopharyngoplasty (UPPP)
  - Visual Correction surgery, Blepharoplasty

  Specific services in an office setting (place of service 11) will require authorization; see link above for the list of specific CPT/HPCS codes.
- Bariatric procedures and treatment related to obesity
- Durable Medical Equipment – follow ODJFS guidelines
- Experimental/Investigational procedures (excluded from coverage)
- Home Health Care
- Home Infusion
- Injectible Medications and Immunoglobulins (examples include: Enbrel, Lupron, Remicade, Interferon, Xolair, Humira, Raptiva, Amevive, blood or blood factors, Synagis).
  - Unlisted injectible codes with charges exceeding $500
- Inpatient Admissions (Skilled Nursing Facility, surgical, medical, obstetric, rehabilitative)
- Radiology: MRI, MRA, PET SCAN, SPECT
- Referrals to Any Non-Participating Providers – including second opinions
- Transplant Evaluations, Transplants and Related Procedures

*For Alcohol and Chemical Dependency Treatment **(except at ODADAS facilities)** and Mental Health Services **(except at Community Mental Health Centers)** – Providers or Members may inquire about these services by calling Molina Healthcare of Ohio at **(800) 642-4168.***

PLEASE NOTE: Abortions, Hysterectomies and **Sterilizations** do not require clinical review. However, claims for these services cannot be paid until the appropriate **ODJFS Consent Form** is received.

Elective Admissions require prior authorization. All emergent admissions require notification within 24 hours of admission or next business day.

Prior Authorization Request Submission

Requests for service requests to the Utilization Management Department may be sent by telephone, fax, mail, or on the web via Molina's ePortal. Phone numbers and address are:

Telephone:	**(800) 642-4168 (option 1, option 1)**	ePortal:	**www.MolinaHealthcare.com**
Fax:	**(866) 449-6843**	Mail:	**Molina Healthcare of Ohio, Inc.**
Member Transportation Information:	**(800) 642-4168 (option 2)**		***Attention: Service Requests***
			PO Box 349020
			Columbus, Ohio 43234-9020

Providers are encouraged to use the Molina Healthcare of Ohio Service Request Form. All requests should include the following information, as applicable, for the requested service:

Required Information for Prior Authorization Requests

- Member demographic information (name, DOB, social security # etc.)
- Provider information (Referring Physician and Referred to Specialist)
- Requested service/procedure (including specific CPT/HCPCS codes)
- Member diagnosis (ICD-9 Code and description)
- Location where the service will be performed
- Requested length of stay (for inpatient requests)
- Clinical indications for the service or referral, including:
  - Adequate patient history related to the requested services
  - Physical examination that addresses the area of the request
  - Supporting lab and/or X-ray results to support the request
  - Relevant PCP and /or Specialist progress notes or consultations
  - Any other relevant information or data specific to the request

Molina Healthcare of Ohio will process any "non-urgent" requests as quickly as possible and no later than within 14 working days of receipt of a request. "Urgent" requests will be processed as soon as possible within 72 hours of receipt of the request.

Upon **approval** the requestor will receive an authorization number. The number may be provided by phone or fax. If a request must be denied, the requestor 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 if at all possible or by fax with confirmation of receipt if telephonic communication fails. Verbal and fax denials are given the same business day of making the denial decision. The written letter is mailed at the time the denial is issued.

Extension of Authorization

Once a service has been previously authorized, the provider may call Molina Healthcare of Ohio directly to request an extension of services.

Appeals

Details regarding the appeals process can be found in the Molina Provider Manual. Members or Providers may call Member Services at **1-800-642-4168** with their appeal or submit the appeal in writing to:

Molina Healthcare of Ohio, Attn: Member Services, PO Box 349020, Columbus, Ohio 43234-9020

Service Request Form (for Prior Authorization)

MOLINA® HEALTHCARE

Service Request Identification #:_____ **Date:**_____

Medical Management
Phone number: **800-642-4168** (option 1, option 1)
Fax number: **866-449-6843**

Member Information

Member Name (Last, First, MI)	Date of Birth / /	Member I.D.
Address: (No., Street, City, State, Zip)		Phone Number: ( )

Service Is: ☐ Medically Emergent (Needed Within 72 Hours) ☐ Elective/Routine

Is there another Insurance Carrier for this service? **Y** **N**
If yes, Name of Company:

Referral/Service Type Requested

Please refer to the Prior Authorization List for those services that require prior authorization

☐ Inpatient Admission
- ☐ Hospital
- ☐ Skilled Nursing Facility
- ☐ Rehabilitation Facility

Facility Name:

Requested Length of Stay:

Date/Time of Service:

*** Requests for hysterectomies, sterilizations and abortions must be accompanied by the appropriate ODJFS form.**

- ☐ Ambulatory Surgical Service
- ☐ Bariatric procedures and treatment
- ☐ Cosmetic/Plastic procedure
- ☐ Durable Medical Equipment
- ☐ Experimental/Investigational procedures
- ☐ Home Health Care, Home Infusion
- ☐ Injectible Medications and Immunoglobulins
- ☐ Pain Management
- ☐ Radiology (MRI, MRA, PET SCAN, SPECT)
- ☐ Referral to non-participating provider including second opinions:
- ☐ Transplant evaluation, procedure
- ☐ Other:_____

Visits requested: _____

☐ DME/Supplies:_____

☐ Injectibles:_____

Place of Service

☐ Provider Office

☐ In Home

Referring Provider Information

Requesting Provider Name: (Last, First)	Specialty:	Phone Number:
Address: (No., Street, City, State, Zip)		Fax Number:
Tax I.D. #:		

Referred to Provider Information

Referred to Provider Name: (Physician, Facility, Agency)	Specialty:	Phone Number
Address: (No., Street, City, State, Zip)		Fax Number
Tax I.D. #:		

Clinical Information

(codes required)

ICD-9 Code **&** Description:	**CPT Code & Description:**	**HCPC & Description:**

Clinical Indications for Request: (may attach clinical or progress notes. Please include pertinent previous testing results):

Requesting Provider Signature: | Date of Scheduled Service (Please include future dates, if applicable): | PCP Name:

For Molina Use Only

Service Request status: ☐ **Approved** ☐ **Pending** ☐ **Denied**	Comments:
Utilization Management Staff Signature:	Date: