Molina Healthcare of Washington
Medicaid and Medicare Prior Authorization Request Form
Phone Number: (800) 869-7185
Fax Number: (800) 767-7188

MEMBER INFORMATION			
Plan:	☐ **Molina Medicaid**	☐ **Molina Medicare**	☐ **Other:**
Member Name:		**DOB:**	/ /
Member ID#:		**Phone:**	( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent*	

***Definition of Urgent / Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition should be submitted as routine / non-urgent.**

	Referral / Service Type Requested	
Inpatient ☐ Surgical procedures ☐ ER Admits ☐ SNF ☐ Rehab ☐ LTAC	**Outpatient** ☐ Surgical Procedure ☐ Diagnostic Procedure ☐ Infusion Therapy ☐ Office Based Hospital Procedures ☐ Other: ☐ Speech/Habilitative Therapy ☐ Hyperbaric Therapy	☐ **Home Health** ☐ **DME** ☐ **In Office (excludes hospital based offices)**

ICD10 Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
Number of visits requested:		DOS:	From: / / to / /

Please send clinical notes and any supporting documentation

PROVIDER INFORMATION			
Requesting Provider Name:			
Facility Providing Service:			
Contact at Requesting Provider's office:			
Phone Number:	( ) -	Fax Number:	( ) -

For Molina Use Only:

NOTES: