

Instructions For Completing Prior Authorization Form (PA-07)

NOTE: ONLY THE FIELDS LISTED BELOW ARE TO BE COMPLETED BY THE PROVIDER OF SERVICE. ALL OTHER FIELDS ARE TO BE USED BY THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA.

- FIELD NO. 2** ENTER RECIPIENT'S 13 DIGIT MEDICAID ID NUMBER OR THE 16-DIGIT CCN NUMBER
- FIELD NO. 3** ENTER THE RECIPIENT'S SOCIAL SECURITY NUMBER
- FIELD NO. 4** ENTER THE RECIPIENT'S LAST NAME, FIRST NAME AND MIDDLE INITIAL AS IT APPEARS ON RECIPIENT'S MEDICAID CARD
- FIELD NO. 5** ENTER THE RECIPIENT'S DATE OF BIRTH IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
- FIELD NO. 6** ENTER THE PROVIDER'S 7-DIGIT MEDICAID NUMBER
- FIELD NO. 7** ENTER THE FIRST DAY THE SERVICE IS REQUESTED TO START AND THE LAST DAY OF SERVICE FOR THAT INDIVIDUAL TREATMENT PLAN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY, YYYY=YEAR)
- FIELD NO. 8** PLACE A CHECK MARK IN THE 'YES' OR 'NO' BOX TO INDICATE WHETHER OR NOT THE RECIPIENT IS CURRENTLY RECEIVING SERVICES
- FIELD NO. 9** ENTER THE NUMERIC ICD9-DIAGNOSIS CODE (PRIMARY & SECONDARY) AND THE CORRESPONDING DESCRIPTION
- FIELD NO.10** ENTER THE DAY THE PRESCRIPTION, DOCTOR'S ORDERS WAS WRITTEN IN MMDDYYYY FORMAT (MM=MONTH, DD=DAY YYYY=YEAR)
- FIELD NO.11** ENTER THE NAME OF THE RECIPIENT'S ATTENDING PHYSICIAN PRESCRIBING THE SERVICES
- FIELD NO.12** ENTER HCPCS CODE
- FIELD NO.12A** ENTER THE CORRESPONDING MODIFIER (WHEN APPROPRIATE)
- FIELD NO.12B** ENTER THE HCPCS CODE'S CORRESPONDING DESCRIPTION FOR EACH PROCEDURE REQUESTED
- FIELD NO.12C** ENTER THE NUMBER OF TIMES THE REQUESTED PROCEDURE WILL BE PERFORMED DURING THE TREATMENT PLAN, CALCULATE THE TOTAL UNITS REQUESTED BY MULTIPLYING THE NUMBER OF UNITS PER DAY (4 UNITS = 1 HOUR) TIMES THE NUMBER OF DAYS PER WEEK TIMES THE NUMBER OF WEEKS REQUESTED (TAKEN FROM THE SERVICES TREATMENT DATES (FIELD NO. 7 ABOVE). THIS WILL GIVE THE TOTAL UNITS REQUESTED.
- EXAMPLE : 11 HOURS PER DAY , 7 DAYS PER WEEK, 26 WEEKS =**
- 11 X 4 = 44 X 7 X 26 WEEKS = 8, 008**
- FIELD NO.13** ENTER THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PROVIDER OF SERVICE
- FIELD NO 14** ENTER THE NAME, MAILING ADDRESS AND TELEPHONE OF THE RECIPIENT'S CASE MANAGER, IF AVAILABLE
- FIELD NO.15** PROVIDER/AUTHORIZED SIGNATURE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF NOT SIGNED. IF USING A STAMPED SIGNATURE, IT MUST BE INITIALED BY AUTHORIZED PERSONNEL.
- FIELD NO.16** DATE IS REQUIRED. YOUR REQUEST WILL NOT BE ACCEPTED IF THIS FIELD IS NOT DATED

IF YOU HAVE ANY QUESTIONS CONCERNING THE PRIOR AUTHORIZATION PROCESS, PLEASE CONTACT THE PRIOR AUTHORIZATION DEPARTMENT AT MOLINA.

HOME HEALTH TOLL-FREE NO. IS 1-800-807-1320

HOME HEALTH PRIOR AUTHORIZATION FAX NUMBER IS 1-225- 237-3342