

Molina for
 Louisiana's **Medicaid Program**
 P. O. Box 14919
 Baton Rouge, LA 70898-4919

PHYSICIAN OUTPATIENT VISIT EXTENSION FORM

(Instructions for completion are on the reverse side of this form.)

I. TREATING PHYSICIAN - Complete this Section:

Date _____

Approval of additional **EMERGENCY** or **LIFE-SUSTAINING** physician outpatient visits is being requested for:

Patient's Name _____

DOB _____

Sex _____

Medicaid Identification Number _____

Social Security Number _____

Provide a specific **DIAGNOSIS CODE** for each **EMERGENCY** or **LIFE-SUSTAINING** visit extension request.
Attach documentation of nature of emergency (Pathology report, clinical notes, etc.)

- | | | | |
|----|---------------|---|---------------------|
| 1. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 2. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 3. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 4. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 5. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 6. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |

- | | | | |
|-----|---------------|---|---------------------|
| 7. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 8. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 9. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 10. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |
| 11. | _____ | / | _____ |
| | Date of Visit | | Diagnosis Treatment |

Physician's Name, Address & Vendor No:

Signature of Treating Physician _____

II. Molina - Prior Authorization Unit Use Only

Extension of physician outpatient visits is approved for

_____	_____	_____	_____	_____
Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit
_____	_____	_____	_____	_____
Date of Visit	Date of Visit	Date of Visit	Date of Visit	Date of Visit

Extension(s) not approved for _____
 Date(s) of Visit(s)

because _____

Date _____

Signature of Reviewing Physician _____