Healthcare Services
84 Loop 410 NE #200
San Antonio, Tx 78216
Phone: (866) 449-6849
Fax: 866-420-3639 (Primary) / 505-924-8280 (Secondary)

To: KETHA, SUMANA	From: Molina HealthCare Inc.
Fax No: 9726757310	Pages: 2
Phone No./Extension: 8886138688	Date: 2/17/2014 8:32:58 AM (PST)

Dear Provider:

This notice is to inform you that this authorization request (see attached) has been forwarded for medical director review. We were unable to establish medical necessity based on the information submitted.

If the health care provider (Physician) who requested the services would like to discuss this case with Molina's medical director prior to issuance of our determination, please call 866-449-6849 extension 206660 for Medicare, STAR, and STAR+PLUS or 877-319-6826 extension 206660 for CHIP. Advise the Healthcare Services team member that you would like to request a peer to peer review. A final decision will be made on this request by the Molina medical director.

Please be advised that Molina is required by regulatory requirements (TDI and HHSC) to issue a determination within 24 hours of receipt of the request for urgent or emergent inpatient services and within 3 days of receipt of request for an elective service that requires prior authorization. If you plan to request a peer to peer review, please initiate the request at your earliest opportunity after receiving this notice.

MOLINA® HEALTHCARE

Molina Healthcare of Texas, Inc.
Fax: 1-866-420-3639
E-Portal: www.molinahealthcare.com

Billing Address:
Molina Healthcare of Texas, Inc.
Long Beach, CA 90801
Electronic: 20554

Service Request Form for Prior Authorization

Authorization #*: _____ **(Include Authorization Number on claim) Molina Representative:** _____

Start Date: 02/11/2014 **End Date**_____**(Contingent on active enrollment)**

Comments: ***ALL ITEMS REQUIRE AN AUTHORIZATION*** *A4335 WIPES 5/MO = $12.77/MO* *A4554 UNDERPADS 150/MO = $51.30/MO*A4402 LUBRICANT JELLY 8/MO = $10.08/MO*A4927 GLOVES 2/MO = $11.48/MO* *A4353 SELF CATH CLOSED SYSTEM 180/MO = $993.06/MO**

*Reference numbers are not a guarantee of reimbursement of the member's medical expenses. Reimbursement is based on eligibility, medical necessity and the benefit provisions of the member's plan at the time services were rendered.

Information Submitted To Molina By: STEPHANIE SCOTT **Date submitted** 02/11/2014

Phone Number: 888-613-8688 Fax Number: 888-901-3496

Member Information

Member Name (Last, First, MI):	Date of Birth:	Member I.D.:
JACKSON, AARON	11/23/1973	506077423
Address: (No., Street, City, State, Zip): 7330 BRIERFIELD DR, DALLAS, TX 75232-4022		Phone Number: ( ) 214-256-6247

Minor Child: ☐ Y ☒ N Parent/Guardian Name (Required for Minors):

Procedure/Service Information** **CODES ARE REQUIRED** ***

Please attach pertinent clinical information, progress notes, and/or diagnostic tests.

ICD-9 Code(s) & Description	CPT Code(s) & Description	HCPC Code(s) & Description
344.00 280.9 401.9 788.30		

☐ Inpatient
☐ 23 Hour Observation
☐ Medical
☐ Obstetrical

Facility Name:

Admit date/time:

Discharge date/time:

☐ Outpatient Procedure:
_____

Date of service (if applicable) _____

☐ Home Health
☐ PT
☐ ST
☐ OT
☐ Evaluation
☐ SNV
☐ PAS
☐ ERS
☐ MOW
☐ Respite
☐ Adult Daycare

Visits Requested
Dates of Service:

☐ DME (Please attach additional sheet w/ codes if needed

Description	Quantity	Duration
A4335 WIPES	5/MO	YR
A4554 UNDERPADS	150/MO	YR
A4402 LUBRICANT JELLY	8/MO	YR
A4927 GLOVES	2/MO	YR
A4353 SELF CATH CLOSED SYSTEM	180/MO	YR

REFERRED FROM:

Prescribing Provider/Attending Physician:	Specialty:	Phone Number:
Address: (No., Street, City, State, Zip – Group Tax ID):		Fax Number:

REFERRED TO:

Provider/ Physician Name:	Specialty:	Phone Number:
St. Louis Medical Supply	DME	855-855-8484
Address: (No., Street, City, State, Zip – Or Group Tax ID): 1664 Larkin Williams Road, Fenton, MO 63026 43-1144291		Fax Number: 877-219-6077
Comments:		

Confirmed receipt: Date: Time: Revised 10.15.10

7195TX1010