

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.

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Fax No: 9726757310

Pages: 2

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Phone No./Extension: 8886138688

Date: 2/17/2014 8:32:58 AM  
(PST)

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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.

**CONFIDENTIALITY NOTICE:** The documents accompanying this telecopy transmission contain confidential information belonging to the sender which is privileged. Å The information is intended only for the use of the individual(s) or entity named above. Å If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Å If you have received this telecopy in error, please immediately notify us via telephone at the number above or return original documents to address listed above.



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: 20534

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

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 <b>344.00 280.9 401.9 788.30</b>	CPT Code(s) & Description	HCPC Code(s) & Description																		
<input type="checkbox"/> Inpatient <input type="checkbox"/> 23 Hour Observation <input type="checkbox"/> Medical <input type="checkbox"/> Obstetrical  Facility Name:  Admit date/time:  Discharge date/time: <input type="checkbox"/> Outpatient Procedure:  Date of service (if applicable) _____	<input type="checkbox"/> Home Health <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> Evaluation <input type="checkbox"/> SNV <input type="checkbox"/> PAS <input type="checkbox"/> ERS <input type="checkbox"/> MOW <input type="checkbox"/> Respite <input type="checkbox"/> Adult Daycare # Visits Requested Dates of Service:	<input type="checkbox"/> DME (Please attach additional sheet w/ codes if needed) <table border="1"> <thead> <tr> <th>Description</th> <th>Quantity</th> <th>Duration</th> </tr> </thead> <tbody> <tr> <td>A4335 WIPES</td> <td>5/MO</td> <td>YR</td> </tr> <tr> <td>A4554 UNDERPADS</td> <td>150/MO</td> <td>YR</td> </tr> <tr> <td>A4402 LUBRICANT JELLY</td> <td>8/MO</td> <td>YR</td> </tr> <tr> <td>A4927 GLOVES</td> <td>2/MO</td> <td>YR</td> </tr> <tr> <td>A4353 SELF CATH CLOSED SYSTEM</td> <td>180/MO</td> <td>YR</td> </tr> </tbody> </table>	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
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#### 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: <b>St. Louis Medical Supply</b>	Specialty: <b>DME</b>	Phone Number: <b>855-855-8484</b>
Address: (No., Street, City, State, Zip – Or Group Tax ID): <b>1664 Larkin Williams Road, Fenton, MO 63026 43-1144291</b>		Fax Number: <b>877-219-6077</b>

Comments:

**WARNING:** Health care information is personal and sensitive information related to a person's health and healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require direct patient authorization. You, the recipient, are obligated to treat this document as PHI and maintain it in a safe, secure and confidential manner. Re-disclosure or unauthorized disclosure is prohibited by law and failure to protect the confidentiality of the PHI could subject to statutory penalties under state or federal law. **Important Message to the Recipient:** If you are not the intended recipient of this confidential and privileged health care information, please notify the sender named at the top of this fax immediately. Disclosure or dissemination of this Personal Health Information is strictly prohibited by law.

Confirmed receipt:

Date:

Time:

Revised 10.15.10