

# MOLINA® HEALTHCARE MEDICAID

## Molina Healthcare of South Carolina, Inc. – Pre-Service Request Form

LAST UPDATED: 12/2025 PHONE: (855) 237-6178

MEMBER INFORMATION					
Line of Business:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace	<input type="checkbox"/> Medicare	Date of Request:	
State/Health Plan (i.e. CA): _____					
Member Name: _____			DOB (MM/DD/YYYY): _____		
Member ID#: _____			Member Phone: _____		
Service Type:		<input type="checkbox"/> Non-Urgent/Routine/Elective <input type="checkbox"/> Urgent/Expedited – <b>Clinical Reason for Urgency Required:</b> _____ <input type="checkbox"/> EPSDT/Special Services			
REFERRAL / SERVICE TYPE REQUESTED					
Request Type:		<input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/ Renewal / Amendment	Previous Auth#:	
Inpatient Services:		Outpatient Services:			
<input type="checkbox"/> Inpatient Hospital <input type="checkbox"/> Inpatient Transplant <input type="checkbox"/> Inpatient Hospice <input type="checkbox"/> Long Term Acute Care (LTAC) <input type="checkbox"/> Acute Inpatient Rehabilitation (AIR) <input type="checkbox"/> Skilled Nursing Facility (SNF) <input type="checkbox"/> Other Inpatient: _____		<input type="checkbox"/> Chiropractic <input type="checkbox"/> Dialysis <input type="checkbox"/> DME <input type="checkbox"/> Genetic Testing <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> Hyperbaric Therapy <input type="checkbox"/> Imaging/Special Tests	<input type="checkbox"/> Office Procedures <input type="checkbox"/> Infusion Therapy <input type="checkbox"/> Laboratory Services <input type="checkbox"/> LTSS Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Outpatient Surgical/Procedures <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Transplant/Gene Therapy <input type="checkbox"/> Transportation <input type="checkbox"/> Wound Care <input type="checkbox"/> Other: _____	
PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION					
Primary ICD-10 Code:		Description:			
DATES OF SERVICE START	STOP	PROCEDURE/ SERVICE CODES	DIAGNOSIS CODE	REQUESTED SERVICE	REQUESTED UNITS/VISITS
PROVIDER INFORMATION					
Requesting Provider / Facility:					
Provider Name:		NPI#:		TIN#:	
Phone:		FAX:		Email:	
Address:		City:		State:	Zip:
PCP Name:				PCP Phone:	
Office Contact Name:				Office Contact Phone:	
Servicing Provider / Facility:					
Provider/Facility Name (Required):					
NPI#:	TIN#:	Medicaid ID# (If Non-Par):			<input type="checkbox"/> Non-Par <input type="checkbox"/> COC
Phone:	FAX:	Email:			
Address:		City:		State:	Zip:

Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.