

Passport by Molina® Healthcare of Kentucky

Marketplace Pre-Service Review Guide

Effective: 01/01/2026

REFER TO MOLINA'S PROVIDER WEBSITE/PRIOR AUTHORIZATION LOOK-UP TOOL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION

ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS
DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

- **Advanced Imaging and Specialty Tests**
- **Behavioral Health, Mental Health, Alcohol and Chemical Dependency Services:**
 - Inpatient (requires notification and concurrent review), Residential Treatment, Partial Hospitalization, Day Treatment
 - Intensive Outpatient requires review above 16 units
 - Electroconvulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS)
 - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD)
- **Cardiology¹:** Select services are administered by Evolent.
- **Cosmetic, Plastic and Reconstructive Procedures** No PA required with Breast Cancer Diagnoses.
- **Durable Medical Equipment**
- **Elective Inpatient Admissions:** Acute Hospital, Skilled Nursing Facilities (SNF), Acute Inpatient Rehabilitation, Long Term Acute Care (LTAC) Facilities
- **Experimental/Investigational Procedures**
- **Genetic Counseling and Testing**
- **Healthcare Administered Drugs**
- **Home Healthcare Services (including home-based PT/OT/ST)**
- **Hyperbaric/Wound Therapy**
- **Long Term Services and Supports (LTSS):** Not a covered benefit.
- **Miscellaneous & Unlisted Codes:** Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request.
- **Neuropsychological and Psychological Testing** after initial testing
- **Non-Par Providers/Facilities:** With the exception of some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service require approval.
 - Local Health Department (LHD) services
 - Hospital Emergency services
 - Evaluation and Management services associated with inpatient, ER, and observation or facility stay (POS 21, 22, 23, 31, 32, 33, 51, 52, 61)
 - Radiologists, anesthesiologists, and pathologists' professional services when billed in POS 19, 21, 22, 23, 24, 51, 52
 - Other services based on State requirements
- **Occupational, Physical & Speech Therapy:** After the first 12 visits for PT/OT or first 6 visits for ST
- **Oncology¹:** Select services are administered by Evolent.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures**
- **Pain Management Procedures**
- **Prosthetics/Orthotics**
- **Radiation Therapy and Radiosurgery¹:** For adults only, select services are administered by Evolent.
- **Sleep Studies**
- **Transplants including Solid Organ and Bone Marrow** (Cornea transplant does not require authorization).
- **Vision:** Pediatric Low Vision Optical Devices and Services: Please contact VSP (Vision Service Plan) at 1 (800) 877-7195 or visit their website at www.vsp.com/advantage

¹ Services provided by Evolent - Cardiology Authorizations for Adults: applies to FL, MI, MS, NV, OH, SC, WA, WI. Oncology Authorizations for Adults: applies to CT, FL, MS, SC, WA, WI. See below for contact information.

Important Information for Molina Healthcare Providers

Information generally required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services.
- Relevant physical examination that addresses the problem.
- Relevant lab or radiology results to support the request (including previous MRI, CT, Lab, or X-ray report/ results).
- Relevant specialty consultation notes.
- Any other information or data specific to the request.

The Urgent / Expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize their ability to regain maximum function. Requests outside of this definition will be handled as routine / non-urgent.

- If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the provider by telephone, fax, or electronic notification. Verbal, fax, or electronic denials are given within one business day of making the denial decision or sooner if required by the member's condition.
- Providers and members can request a copy of the criteria used to review requests for medical services.
- Molina Healthcare has a full-time Medical Director available to discuss medical necessity decisions with the requesting physician at (800) 578-0775.

Important Molina Healthcare Marketplace Contact Information

Kentucky (Service hours 8am-5pm local M-F, unless otherwise specified)

Prior Authorizations including Behavioral Health

Authorizations:

Phone: (800) 578-0775

Fax: (833) 322-1061

Pharmacy Authorizations:

Phone: (800) 578-0775

Fax: (844) 802-1406

Radiology Authorizations:

Phone: (855) 714-2415

Fax: (877) 731-7218

Provider Customer Service:

Phone: (800) 578-0775

Vision:

Phone: (800) 877-7195

Website: www.vsp.com/advantage

Member Customer Service, Benefits/Eligibility:

Phone: (888) 898-7969/ TTY/TDD 711

Transplant Authorizations:

Phone: (855) 714-2415

Fax: (877) 813-1206

ProgenyHealth:

Phone: 1-888-832-2006

Fax: (855) 768-3714

UM Email: molinamarketplaceum@progenyhealth.com

CM Email: molinamarketplacecm@progenyhealth.com

24 Hour Nurse Advice Line (7 days/week)

Phone: (888) 275-8750/TTY: 711

Members who speak Spanish can press 1 at the IVR (Interactive Voice Response) prompt. The nurse will arrange for an interpreter, as needed, for non-English/Spanish speaking members. No referral or prior authorization is needed.

New PA process

The process for obtaining Prior Authorization has changed. Molina is transitioning to a digital first PA model to expedite the review process in compliance with CMS-0057. Please use the [Availity Essentials Portal](#) to submit all Prior Authorization Requests, including all pertinent information and clinical records.

Providers may utilize Molina Healthcare's Website at: <https://provider.molinahealthcare.com/Provider/Login>

Available features include:

- | | |
|---------------------------------------|---|
| • Authorization submission and status | ☐ Claims submission and status |
| • Member Eligibility | ☐ Download Frequently used forms |
| • Provider Directory | ☐ Nurse Advice Line Report |
-



Molina® Healthcare, Inc. – Pre-Service Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (e.g., CA):				
Member Name:			DOB (MM/DD/YYYY):	
Member ID#:			Member Phone:	
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency Required: _____ ☐ EPSDT/Special Services			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ Initial Request	☐ Extension/ Renewal / Amendment	Previous Auth#:	
Inpatient Services:	Outpatient Services:			
☐ Inpatient Hospital ☐ Inpatient Transplant ☐ Inpatient Hospice ☐ Long Term Acute Care (LTAC) ☐ Acute Inpatient Rehabilitation (AIR) ☐ Skilled Nursing Facility (SNF) ☐ Other Inpatient: _____	☐ Chiropractic ☐ Dialysis ☐ DME ☐ Genetic Testing ☐ Home Health ☐ Hospice ☐ Hyperbaric Therapy ☐ Imaging/Special Tests	☐ Office Procedures ☐ Infusion Therapy ☐ Laboratory Services ☐ LTSS Services ☐ Occupational Therapy ☐ Outpatient Surgical/Procedures ☐ Pain Management ☐ Palliative Care	☐ Pharmacy ☐ Physical Therapy ☐ Radiation Therapy ☐ Speech Therapy ☐ Transplant/Gene Therapy ☐ Transportation ☐ Wound Care ☐ 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):	☐ Non-Par ☐ 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.



Molina® Healthcare, Inc. – BH Pre-Service and Concurrent Review Request Form

MEMBER INFORMATION

Line of Business:	☐ Medicaid	☐ Marketplace	☐ Medicare	Date of Request:
State/Health Plan (i.e., CA):				
Member Name:				DOB (MM/DD/YYYY):
Member ID#:				Member Phone:
Service Type:	☐ Non-Urgent/Routine/Elective ☐ Urgent/Expedited – Clinical Reason for Urgency Required: _____ ☐ Emergent Inpatient Admission			

REFERRAL/SERVICE TYPE REQUESTED

Request Type:	☐ Initial Request	☐ Extension/ Renewal / Amendment	Previous Auth#:
Inpatient Services:	Outpatient Services:		
☐ Inpatient Psychiatric ☐ Involuntary ☐ Voluntary ☐ Inpatient Detoxification ☐ Involuntary ☐ Voluntary If Involuntary, Court Date: _____	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Intensive Outpatient Program ☐ Day Treatment ☐ Assertive Community Treatment Program ☐ Targeted Case Management ☐ Electroconvulsive Therapy ☐ Psychological/Neuropsychological Testing ☐ Applied Behavioral Analysis ☐ Non-PAR Outpatient Services ☐ Other: _____		

PLEASE SEND CLINICAL NOTES AND ANY SUPPORTING DOCUMENTATION

Primary ICD-10 Code for Treatment:

Description:

DATES OF SERVICE START	DATES OF SERVICE 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):	☐ Non-Par ☐ 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.