Paper Referral Form Instructions

The Paper Referral Form is an option to communicate a referral and must be printed and filled out manually. Paper referrals should be sent to the referred-to provider and not e-mailed, faxed, or mailed to Molina or Healthy Connections. It is the responsibility of the referred-to provider to ensure a documented referral is in place prior to billing for services.

To submit referrals electronically, sign into your Trading Partner Account on the Molina Medicaid Web site.

Participant Information: (*all fields are required*)

1. Date: Enter the date this form was filled out.
2. Participant Name: Enter the participant name
3. Participant Medicaid #: Enter the participant ID number (MID)
4. Participant Date of Birth: Enter the participant date of birth MM/DD/YYYY

Referring Primary Care Provider: (*all fields are required*)

1. Primary Care Provider Organization Name: Enter in the Organization name
2. Provider Billing NPI #: Enter in the billing provider NPI #
3. Specific Referring Provider Name: Enter in the name of the provider who is referring the service
4. Primary Care Provider Clinic Phone Number: Enter in the phone number of the service location
5. Referring Provider's Signature: Enter in the signature of the referring provider

Referral Information: (*all fields are required*)

1. Enter the Referral:
2. Enter Start Date of referral
3. Enter End Date of referral (up to 365 days)
4. Enter Visits/Units (if applicable)
5. Referred To Provider or Group:
6. Enter Referred to Provider or Clinic name
7. Enter Provider Billing NPI #
8. Enter Provider Phone Number
9. Enter Provider Address

Referral Approval Reasons: (*all fields are required*)

1. Check the applicable box for the type of referral reason (choose one)
   a. Assume Care
   b. Consultation/Diagnosis Only
   c. Diagnose & Treat
   d. Diagnose & Treat to include surgery
   e. Diagnosis, treat & forward to specialty provider(s) for this condition
   f. Hospital Admission
   g. One-time visit until seen by PCP
   h. Follow patiently jointly
   i. *DME
   j. *Mental Health Services
   k. *Developmental Disability Services
   l. *Other-describe

If the reason selected has an (*), you must specify the services included in the referral using the notes section.