

**Idaho Medicaid Lab Prior Authorization Form**  
**Fax to: (877) 314-8779**

**Date Faxed to Medicaid:**

**Proposed Date(s) of Service:**

**Medicaid Participant Information**

Last Name:

First Name:

Initial:

Medicaid ID Number:

Date of Birth:

**Physician Information**

Physician Name:

Phone:

Address:

**Lab Provider Information**

Provider Name:

NPI:

Contact Name:

Phone:

Email:

**Diagnosis and Requested Lab**

Diagnosis:

CPT Codes	Description	Quantity

**Required Documentation**

Has the physician and member discussed the potential results of the test and agreed that the results will be used to guide therapy?

Yes

No

Please fax all medical documentation that supports medical necessity. For example, progress notes, and a letter of medical necessity demonstrating a plan for how test results will direct care.

**Notes**

For questions regarding authorization number, requirements, limitation or status, call Molina Customer Service at 1 (866) 686-4272 or see the Molina HealthPAS portal at [www.idmedicaid.com](http://www.idmedicaid.com).