

Mail or Fax completed form to:
DPHHS
PO Box 202951
Helena, MT 59602
Fax: 406-444-1861
Physician Program: 406-444-3995
Hospital: 406-444-7018



Montana Healthcare Programs

Request for Physician Administered Drug Prior Authorization

Please type or print:

Today's Date: _____ Contact Person: _____ Phone Number: _____

Patients Name (Last,First, MI): _____ Medicaid #: _____ Date Of Birth: _____

Therapy will be provided in:

Provider Office: ____ Outpatient Hospital (Infusion Ctr, CAH, etc.): ____ ASC: ____

Rendering Provider Name: _____ NPI (not TIN): _____ Fax Number: _____

If applicable, Outpatient

Hospital or ASC Facility Name: _____ NPI (not TIN): _____ Fax Number: _____

HCPCS Code: _____ Diagnosis-ICD 10: _____ Description: _____

NDC: _____ Units per Treatment: _____

Is this an extension of an existing prior authorization?

Yes ____ No ____

Date Therapy Will Be Initiated: _____

Pertinent Information: _____

Dosage & Therapy Plan:

Medical Records Attached Yes ____ No ____

Prior Authorization Unit Only

Important Note: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to bill correctly and to verify Medicaid eligibility. Current member eligibility may be verified by calling Conduent State Healthcare, LLC at 1-800-9624-3958 or 406-442-1837

Date: _____ Approval/Denial Status: _____ Date Spans Approved: _____

Reason for denial of therapy prior authorization: _____

HCPCS Code: _____ Prior Authorization Number: _____