Adult Mental Health Services
DPHHS Montana Medicaid

Exception to 24 Sessions Request Form

Fax confidential request information to 1-406-444-7391.

PLEASE PRINT OR TYPE. Date _____

PATIENT INFORMATION		
Patient Name	**Medicaid Number**	**Birthdate**

PROVIDER INFORMATION	
Provider Name	
Address	**Provider NPI Number**
City, State, and ZIP Code	**Medicaid Provider ID Number**
Telephone Number	**Fax Number**

CLINICAL INFORMATION

Any changes in DSM diagnoses, including co-occurring disorders, medical conditions

Code	**Narrative**
Code	**Narrative**
Code	**Narrative**

Date of Session 24	**Number of Additional Sessions Requested:**

Current Psychological Symptoms, Behaviors, and Level of Functioning That Necessitate Continued Outpatient Sessions

Changes to Medication or Treatment Plan

Discharge Plan

PLEASE PRINT	**Assessment Completed By**

Signature	**Title**	**Date**

CPT code requested	**PA #**