



COUNTY USE ONLY: Case No. _____

MEDICAID SERVICES ESSENTIAL FOR EMPLOYMENT

NAME: _____ (Please Print) SOCIAL SECURITY NUMBER: _____

- INSTRUCTIONS:**
- The Medicaid recipient/case manager is to complete sections (1) and (3), then sign and date the form. **Medicaid Recipient does NOT complete shaded sections.**
 - The Medicaid provider is to complete section (2) below, then sign and date that section in the shaded area.
 - **A separate form must be completed for each service requested.**

REQUEST REQUIREMENTS

1. EMPLOYABILITY: (To be completed by MEDICAID RECIPIENT/CASE MANAGER)

Briefly describe why this service is needed to seek, obtain or maintain employment: _____

List name and address of employer (if working): _____

Date employment/job search started/will start: _____

Average weekly hours worked/seeking employment (**attach verification**): _____

Is this employment temporary? If yes, when is it expected to end? _____

If employed, please list your major job duties (i.e., greeting the customer, answering the phone, operating machinery, filling orders, etc.) _____

2. MEDICAL: (To be completed by MEDICAID PROVIDER)

List medical service required: (**Attach specific codes and description of plan, if possible**) _____

Medicaid provider name (please print): _____

Medicaid provider signature: _____ Date: _____

IF APPROVED, RECIPIENT WILL BE AT REGULAR MEDICAID RATES

▶ INDIVIDUAL MUST BE RECEIVING MEDICAID AT THE TIME OF SERVICE, OR CLAIM WILL BE DENIED

3. RESOURCES EXPLORATION: (To be completed by MEDICAID RECIPIENT/CASE MANAGER)

Please list other resources you have explored to obtain this medical service (i.e., have you contacted your county public health department? Lion's Club? Vocational Rehabilitation?). _____

▶ **Prescriptions, x-rays and lab tests are not covered by the Essential for Employment program. Eyeglasses prescribed must be selected through and billed by Walman. If eyeglasses are not selected through and billed by Walman, the Medicaid Recipient will be responsible to pay for the eyeglasses.**

I certify the information I have provided on this form is true and correct to the best of my knowledge.
Medicaid Recipient Signature: _____ Date: _____

I have reviewed this form and the attached verification. Alternative community resources have been explored with the recipient.

County Director or Designee Signature: _____ Date: _____

*** Unsigned forms will be returned to the County Office.**

Submit form, along with the required verification, to Screening Committee for review.

Policy & Systems Bureau, P.O. Box 202925, Helena, MT 59620-2925

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SCREENING RESULTS

NOTE: In order for this service to be covered by Medicaid, the individual must be receiving Medicaid at the time the service(s) is rendered, all three sections below must be marked as approved, and all must be signed and dated. Incomplete forms or the individual not receiving Medicaid at the time of service will result in Medicaid not covering the service(s).

4. REVIEW OF "ESSENTIAL FOR EMPLOYMENT" CRITERIA: (To be completed by POLICY & SYSTEMS BUREAU)
Policy & Systems Bureau (PSB): APPROVES: _____ DENIES: _____ this request.

Explanation of approval or denial: _____

PSB Signatures and Titles: (a) _____
(b) _____

5. REVIEW OF COVERAGE: (To be completed by MEDICAID SERVICES)
The requested service is: APPROVED: _____ DENIED: _____ Medicaid coverage.

Explanation of approval or denial: _____

Signature(s): _____ Date: _____
_____ Date: _____

6. AUTHORIZATION: (To be completed by POLICY & SYSTEMS BUREAU)
Authorization is: APPROVED: _____ DENIED: _____

Signature: _____ Date: _____
(Policy & Systems Bureau)

If approved, this authorization will override the benefit restrictions that apply to Basic Medicaid recipients. **ALL OTHER PROGRAM LIMITATIONS AND PRE-APPROVAL REQUIREMENTS STILL APPLY.**

MEDICAID PROVIDER: This authorization is valid for a maximum of 180 days, and only if the individual is receiving Medicaid at the time the service is rendered. All services completed more than 180 days after the approval date, or while the individual is not receiving Medicaid will be denied. **Contact XEROX to verify eligibility prior to performing any procedure or before each visit for a service.**

Medicaid provider should take the approved form to Medicaid provider. Provider should retain a copy in his/her files.

INSTEAD PROVIDER ATTACH PINK COPY OF APPROVED FORM TO CLAIM AND SUBMIT TO:

MEDICAID SERVICES, PO BOX 202951, HELENA, MT 59620-2951

Claims sent directly to XEROX will be denied

ATTACHMENTS: Supporting documentation to justify medical need of the requested item must accompany this form. Documentation includes, but is not limited to a prescription, Certificate of Medical Need (if required) and the patient's primary care provider's narrative description detailing need for the item. If being treated by a licensed therapist, a copy of the patient's plan of care and narrative summary supporting the request are required.