

Mountain-Pacific Quality Health

Request for Medicaid Home Infusion Therapy Authorization

Please type or print.

Home IV Contact Person					
Patient Name (Last, First, MI)			Medicaid Number	Date of Birth	
Physician Name		Address, City, State, ZIP		Telephone / Fax	
Provider NPI/API	Provider Name			Telephone / Fax	
Street Address, City, State, ZIP					
Date Therapy Initiated			Is this an extension of an existing prior authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Pertinent Information (C&S, chart notes, etc.) <input type="checkbox"/> Attached					
Diagnosis / Additional Comments					
Services to be Authorized					
From	Through	Procedure	Days	Therapy	
1.					
2.					
3.					
4.					
5.					
Mail or fax completed form to: Drug Prior Authorization Unit Mountain-Pacific Quality Health 3404 Cooney Drive, Helena, MT 59602 406.443.6002 or 1.800.395.7961 Phone 406.513.1928 or 1.800.294.1350 Fax					
Prior Authorization Unit Use Only					
Reason for denial of therapy prior authorization.					
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 verify Medicaid eligibility. Current member eligibility may be verified by calling Conduent State Healthcare, LLC, at 1.800.624.3958 or 406.442.1837.					
Approval/Denial Status	Approve/Deny Code	Therapeutic Class	Authorization ID	Date of Request	Prior Authorization Number