DPHHS Optometric Program Officer
Fax (406) 444-1861

Montana Medicaid or Healthy Montana Kids (HMK) Prior Authorization Request

Eyeglass Additional Feature and Contact Lens

To facilitate prompt and accurate processing, the information below must be complete and any additional information for this request must be submitted with this form.

Today's Date _____

Member Information		
Last Name First Name MI	**Member ID**	**Date of Birth**

Service Type. Check all that apply.			
☐ Photochromatic (transition)	☐ Polycarbonate	☐ Contact lens exam/fitting	☐ Tint other Rose 1 or 2
☐ Deluxe Frame	☐ Fresnel Prism, press on	☐ Contact lens supply	☐ 2 pair eyeglasses

Procedure Code, if applicable.
Procedure Code if applicable.
Date of Visit or Procedure

Pay-To Provider Information	
Provider Name	**Provider NPI**

Rendering Provider Information	
Provider Name	**Provider NPI**

Prior Authorization Submitter Contact Information		
Contact Name	**Telephone**	**Fax**

Additional Information for medical necessity (required)
_____
_____
_____