



# 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.			
<input type="checkbox"/> Photochromatic (transition)	<input type="checkbox"/> Polycarbonate	<input type="checkbox"/> Contact lens exam/fitting	<input type="checkbox"/> Tint other Rose 1 or 2
<input type="checkbox"/> Deluxe Frame	<input type="checkbox"/> Fresnel Prism, press on	<input type="checkbox"/> Contact lens supply	<input type="checkbox"/> 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)			