Mail or Fax completed form to:
DPHHS
PO Box 202951
Helena, MT 59602
Fax: 406-444-1861
Physician Program: 406-444-3995
Hospital: 406-444-7018

Montana Healthcare Programs

Request for Physician Administered Drug Prior Authorization

Please type or print:

Todays Date: _____ Contact Person:_____ Phone Number: _____

Patients Name (Last,First, MI): _____ Medicaid #: _____ Date Of Birth:_____

Therapy will be provided in:

Provider Office: ____ Outpatient Hospital (Infusion Ctr, CAH, etc.): ___ ASC: ___

Rendering Provider Name: _____ NPI (not TIN): _____ Fax Number: _____

If applicable, Outpatient
Hospital or ASC Facility Name: _____ NPI (not TIN): _____ Fax Number: _____

HCPCS Code: _____ Diagnosis-ICD 10: _____ Description: _____

NDC: _____ Units per Treatment: _____

Is this an extension of an existing prior authorization?
Yes ___ No ___

Date Therapy Will Be Initiated: _____

Pertinent Information: _____
_____

Dosage & Therapy Plan: _____
_____
_____

Medical Records Attached Yes ___ No ___

Prior Authorization Unit Only

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 bill correctly and 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

Date: _____ Approval/Denial Status: _____ Date Spans Approved**:** _____

Reason for denial of therapy prior authorization: _____

HCPS Code: _____ Prior Authorization Number: _____