Mail or Fax completed form to:
DPHHS
PO Box 202951
Helena, MT 59602
Fax: 406-444-1861
Physician Program: 406-444-3995
Hospital: 406-444-4834

# Montana Healthcare Programs

## Request for Physician Administered Drug Prior Authorization

**Please type:**

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: ___ Group/Clinic:____

_____

Rendering Provider Name: _____ NPI:_____ Fax Number: _____

Facility Name:_____ NPI:_____ 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 ___

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**Important Note**: Prior authorization is determined using published criteria only. Prior authorization does not guarantee payment of claim. Please remember to check eligibility of the member the day of service. If you have a claim that has denied, please contact Provider Relations at 1-800-624-3958.