

Mountain-Pacific Quality Health
Request for Medicaid Home Infusion Therapy Authorization
Note: This form is only for S Codes

Please type or print.

Home IV Contact Person			
Patient Name (Last, First, MI)		Medicaid Number	Date of Birth
Physician Name		Address, City, State, ZIP	
Pharmacy NPI/API		Provider Name	
Pharmacy 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	Service Code	Modifier Code	Days	Drug Requested
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 Montana Provider Relations, 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
----------------------------	-----------------------	----------------------	------------------	--------------------	----------------------------------