Montana Medicaid Adult* Certificate of Need

Out of State Adult Acute Behavioral Health Inpatient Hospitals**

Adult Information

NAME:			**DOB:**	**SSN:**	
ADDRESS:		**CITY:**		**STATE:**	**ZIP:**
ADMITTING FACILITY:				**MEDICAID NUMBER:**	
PROPOSED ADMIT DATE:	**EXPECTED DISCHARGE DATE:**	**PROVIDER NUMBER:**	**NPI NUMBER:**	**TAXONOMY:**	

AT THE TIME OF ADMISSION, THE INTERDISCIPLINARY TEAM CERTIFIES THE FOLLOWING:

(1) **Ambulatory care resources available in the community <u>do not</u> meet adult's treatment needs (include documentation):**

(2) **Proper treatment of adult's psychiatric condition requires services on inpatient basis <u>under physician direction</u> (include documentation):**

(3) **Services can reasonably be expected to improve adult's condition or prevent further regression so that services will no longer be needed (include documentation):**

PRINT / TYPE NAME OF PHYSICIAN TEAM MEMBER	**TITLE**	**DATE**
SIGNATURE OF PHYSICIAN TEAM MEMBER	**PHONE NUMBER**	
PRINT / TYPE NAME OF MENTAL HEALTH PROFESSIONAL	**TITLE**	**DATE**
SIGNATURE OF MENTAL HEALTH PROFESSIONAL	**PHONE NUMBER**	
PRINT / TYPE NAME OF INDIVIDUAL COMPLETING FORM	**TITLE**	**DATE**
SIGNATURE OF INDIVIDUAL COMPLETING FORM	**PHONE NUMBER**	

Processing May Be Delayed if Information Submitted is Illegible or Incomplete

Mountain Pacific Quality Health

Fax: 877-428-0604 / Questions: 800-262-6595

*** Only required for members 18-21 years of age**

**** Complies with the Code of Federal Regulations**