State of Montana PharmAssist Program
Contractor Packet

1. Please complete with the patient pages 3-7 and return in the envelope provided or Fax 443-2580 (please include cover sheet and return fax number).
2. Once Mountain-Pacific Quality Health receives pages 3-7 they will review the information to determine if there is an opportunity for the patient to benefit from a pharmacist consultation.
3. If determined that the patient will benefit from a consultation, Mountain-Pacific Quality Health will send you, the Contractor, a Prior Authorization number that **MUST** be included on "Initial Consultation Invoice" to receive payment.
4. If determined that the patient will **not** benefit from a consultation Mountain-Pacific Quality Health will send you, the Contractor, a letter indicating that a Prior Authorization number will not be generated and why. The patient will also be notified by letter.
5. When you, the Contractor, receive the Prior Authorization number you will have two weeks* to perform a face-to-face consultation with the patient to complete pages 11-13. *To request additional time – Call the DPHHS Pharmacist (406) 444-5951.
6. Following the consultation, you will have one week to provide a care plan, letter to the patient and to all appropriate healthcare providers, outlining your consultation recommendations.
7. Following the consultation, you, the contractor, will have one week to mail the following documents to Mountain-Pacific Quality Health:
   Completed form "**Initial Consultation Invoice,**" page 14.
   Contractor Packet pages 3-7 and 11-13.
   Copy of recommendation letters and care plan for the patient and healthcare provider(s).

8. **If you, the Contractor, request Follow-up on the Initial Consultation Invoice:**
   - MPQH will indicate approval or disapproval of the requested Follow-up in the section provided on the Initial Consultation Invoice and forward the Initial Consultation Invoice to the MT PharmAssist Supervisor for payment processing.
   - The MT PharmAssist Supervisor will mail the Follow-up Consultation Invoice form to you, the Contractor.

   Upon completing the Follow-up Consultation, you, the Contractor, will mail the following to MPQH:
   - Completed form titled "**Follow-up Consultation Invoice**".
   - Copy of follow-up recommendation letter(s) for patient and healthcare provider(s).

If **additional Follow-up Consultation** is requested on the **Follow-up Consultation Invoice**: **Repeat 8. as needed.**

State of Montana PharmAssist Program

Montana PharmAssist is a State of Montana program administered by the Department of Public Health and Human Services and is funded by the tax on tobacco products.

The PharmAssist program is open to all Montana citizens, regardless of age or income, who will benefit from an in- depth consultation.

The goals of the program are to offer any Montana citizen:

- An avenue to investigate ways of controlling medication costs, maximize drug therapies and at the same time derive additional health benefits from proper and prudent use of medications.
- An opportunity to build and strengthen the relationship with their community pharmacist. The pharmacist is providing medication management recommendations.
- An opportunity to improve communication with their healthcare provider.
- An opportunity to receive education and support for efforts in taking a more active role in their own healthcare regimen.

Other goals are:

- To improve communication between primary-care providers and pharmacists: Pharmacists involved in this program are not diagnosing, treating medical conditions or prescribing medications. The pharmacist is providing medication management recommendations.
- Pharmacists involved will provide a comprehensive accounting of all medical conditions and medication therapies, giving a more complete picture for building personalized treatment plans.

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

Please list all **prescription and non-prescription** (over the counter including vitamins, herbal supplements, etc.) medications that you are currently taking:

Name of Medication	Dose	How often do you take this medication?	How long have you been on this medication?	What do you take this medication for?	Who prescribed this medication?

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

Please mark all of the medical conditions you currently have or have been diagnosed with in the past:

- □ Alcohol Abuse
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Asthma or Emphysema
- □ Bleeding or Clotting Disorder
- □ Cancer
- □ Chest Pain
- □ Chronic Lung Disease
- □ Confusion or Memory Loss
- □ Depression or Anxiety
- □ Diabetes
- □ Diarrhea
- □ Glaucoma
- □ Headaches or Migraines
- □ Heart Attack
- □ Heart Disease
- □ Hepatitis or Liver Disease
- □ HIV or AIDS
- □ High Blood Pressure
- □ High Cholesterol
- □ Kidney Disease or Dialysis
- □ Organ Transplant
- □ Pregnancy/Breastfeeding
- □ Rheumatic Fever
- □ Seizures
- □ Stomach Ulcer
- □ Thyroid Disorder
- □ Other (please specify)

_____

Please list any concerns you would like to have addressed by the consulting pharmacist:

_____

_____

_____

_____

Is there a specific participating pharmacist you would like to request? _____

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

State of Montana Department of Public Health and Human Services

NOTICE OF USE OF PROTECTED HEALTH INFORMATION

Effective Date April 14, 2003

For your Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Private Application Information

You are applying for government programs that provide money or services. Before we can review your Application, we ask that you provide some personal information.

The laws say that:

1. We must keep your Protected Health Information ("PHI") from others who do not need to know it; and
2. You can tell us if there is some PHI you do not wish to be shared. However, in some cases, we may not be able to agree to your request.

Who Sees and Shares My Application and Medical Information?

Unless you tell us differently on your Application, we may share your Application information with other programs that may be able to help you. Some are programs for children, people with disabilities, and people who need financial help. If one of these programs can help you, they will contact you.

Healthcare providers who treat you may use your PHI. This may cover healthcare you have had in the past or may have in the future. We may also use your PHI to contact you about appointment reminders or to tell you about treatment alternatives. We only share the minimum necessary PHI that is needed at the time by that provider or agency.

How is Payment Made?

Your healthcare provider sends a claim to an insurance company or to a government program for payment. That claim contains all the information about the services you were provided.

Claims that are sent to us are reviewed to assure that you receive the quality health care every client deserves and that all laws governing medical care are being followed.

May I See Medical Information?

You are allowed to see your PHI unless it is the private notes taken by a mental health provider, it is part of a legal case, or if **My** your healthcare provider decides it would be harmful for you to see the information. Most of the time you can receive a copy if requested. You may be charged a small amount for the copying costs.

If you think some of the information is wrong, you may request, in writing, that it be changed or new information be added. You may ask that the changes be sent to others who have received your PHI. You can request and receive a list showing where your medical information has been sent, unless it was sent as part of your provider's care, or to assure that you received quality care, or to make sure the laws are being followed.

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

What if My Medical PHI Needs to go to Another Location?

Along with page 6 you are being asked to sign page 7, the Authorization for the Use and Disclosure of Health Information, allowing your PHI to be sent to another location. This would be used if your healthcare provider provides it to another location or if you request that we send it to another individual or healthcare provider for you.

The form gives the name and address that we are to send your PHI and the information you wish to be provided.

Your authorization is good for 6 months or until the date you put on the form (not more than 30 months). You can cancel or limit the amount of PHI sent at any time by written notification.

Note: If you are under the age of 18, your parents or guardians will receive your PHI, **unless, by law, you are able to consent for your own healthcare**. If you are, then it will not be shared with them unless you sign an Authorization form**.**

Could My Information be Released Without My Authorization?

We adhere to laws that provide specific instances when medical information must be shared, even if you do not sign an Authorization form. We always report:

1. contagious diseases;
2. reactions and problems with medicines;
3. to the police when required by law or when the courts so order;
4. to the government for audits and reviews of our programs;
5. to a provider or insurance company to verify your enrollment in one of our programs;
6. to Workers' Compensation for work related injuries;
7. birth, death and immunization information; and
8. to the federal government if required to investigate any matter pertaining to the protection of our country, the President or other government workers.

May I have a Copy of this Notice?

Attached is your copy of this notice. If the information changes, you will be provided a copy of the updated Notice. If you have questions concerning this Notice, please ask the individual providing it. If that individual cannot answer your questions, call the Department of Public Health and Human Services ("DPHHS") Privacy Officer at (800) 645-8408.

You can also complain to the federal government Secretary of Health and Human Services by writing to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW - Room 506-F
Washington, D.C. 20201

This must be done within 180 days from the date you believe your privacy was violated. You can also complain to the Office for Civil Rights by calling (866) 627-7748.

Your Medicaid benefits will not be affected by a complaint made to the DPHHS Privacy Officer or to the Secretary of Health and Human Services.

I have been given a copy of this Notice and have been given the opportunity to ask questions concerning how my Protected Health Information will be used. I know that I can contact the DPHHS Privacy Officer at (800) 645-8408 if I have further concerns.

Your Signature _____ **Date**_____

Signature of Authorized Representative (If Applicable) _____**Date** _____

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

AUTHORIZATION For the Use and Disclosure of Health Information

Montana Department of Public Health and Human Services
Montana PharmAssist Program
P.O. Box 202915, Helena, MT 59620-2915

Federal law prohibits your Protected Health Information ("PHI") being shared without your permission except in certain situations. By signing this form, you are giving us permission to share the health information you indicate below. This does not keep the information from being shared with more people once it leaves our office. This authorization will only last until the date you specify, but not longer than thirty months.
If you want to cancel this Authorization at any time, you should sign the AUTHORIZATION REVOCATION below and return it to the Department of Public Health and Human Services ("DPHHS").

I give permission to the Department of Public Health and Human Services Montana PharmAssist Program to share the health information I provide with the Individual(s) or Entity(ies) listed below:

Date: _____

Pharmacist, Physician, Individual or Entity: _____

Pharmacist, Physician, Individual or Entity: _____

Pharmacist, Physician, Individual or Entity: _____

Pharmacist, Physician, Individual or Entity: _____

Your Name Printed: _____**Your Signature** _____

Signature of Authorized Representative (If Applicable) _____**Date** _____

Relationship of Authorized Representative _____

AUTHORIZATION REVOCATION
I no longer want my information shared.

Signature _____**Date** _____

Signature of Authorized Representative (If Applicable) _____**Date** _____

Relationship of Authorized Representative _____

Return pages 3 through 7

Fax: 443-2580 (please include a cover sheet with a return Fax number)

Or

Mail to:

Mountain-Pacific Quality Health
Attn: Montana PharmAssist
3404 Cooney Drive
Helena MT 59602

PATIENT COPY PATIENT COPY PATIENT COPY PATIENT COPY

State of Montana Department of Public Health and Human Services
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Effective Date April 14, 2003

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Signing the Authorization for the Use and Disclosure of Health Information, allows your PHI to be sent to another location. This would be used if your healthcare provider provides it to another location or if you request that we send it to another individual or healthcare provider for you.

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limit the amount of PHI sent at any time by written notification.

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We adhere to laws that provide specific instances when medical information must be shared, even if you do not sign an Authorization form. We always report:

1. contagious diseases;
2. reactions and problems with medicines;
3. to the police when required by law or when the courts so order;
4. to the government for audits and reviews of our programs;
5. to a provider or insurance company to verify your enrollment in one of our programs;
6. to Workers' Compensation for work related injuries;
7. birth, death and immunization information; and
8. to the federal government if required to investigate any matter pertaining to the protection our country, the President or other government workers.

PATIENT COPY PATIENT COPY PATIENT COPY PATIENT COPY

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If you want to cancel this Authorization at any time, you should sign the AUTHORIZATION REVOCATION below and return it to the Department of Public Health and Human Services ("DPHHS").

AUTHORIZATION REVOCATION:

I no longer want my information shared.

Signature _____ **Date** _____

Signature of Authorized Representative (If Applicable) _____ **Date** _____

Relationship of Authorized Representative _____

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

COMPLETE THIS SECTION AFTER PRIOR AUTHORIZATION NUMBER RECEIVED.

Please complete pages 11-13 with the patient as accurately and as completely as possible. All information disclosed is completely confidential. This information will tell us about our patient population and assist you in your consultation to help the patient to make informed health care decisions. If you have any questions, please contact the Montana PharmAssist at 1-866-913-2323.

How did you hear about this program?

□ Primary Health Care Provider
□ Pharmacist
□ Newspaper
□ Radio
□ TV
□ AARP
□ Family/Friend
□ Other (please specify) _____

Do you have health insurance coverage or any medical benefits? □ Yes □ No

If yes, please check all that apply:

□ Medicaid
□ Medicare
□ VA
□ AARP
□ Blue Cross/Blue Shield
□ Other (please specify) _____

Do you have prescription benefits? □ Yes □ No

If yes, please specify which company, and the benefit: _____

What is your annual income? _____

(We ask about your income because it will help your pharmacist determine if you qualify for other community or drug assistance programs.)

What are your income sources?

□ Employed
□ Self-Employed
□ Unemployed
□ Social Security
□ Veterans Benefits
□ Child Support
□ Alimony
□ Pension/Retirement
□ Interest/Dividends
□ Other (please specify)

_____

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

The following information is **optional** and is used only for grant applications from private foundations and the State of Montana. We sincerely appreciate the completion of this part of the form; however, it is not required that you do so.

What is your marital status? □ Single □ Married □ Separated □ Divorced □ Widowed

What is your race or ethnic identity?

□ White/European American
□ African American/Black
□ Alaskan Native
□ Asian
□ American Indian (please specify)_____
□ Hispanic, Latino/a, Chicano (please specify)_____
□ Pacific Islander (please specify)_____

Have you ever had an anaphylactic or serious allergic reaction (turning red, swelling, difficulty breathing)?

□ Yes □ No

Please list any adverse reactions you have had to food or medications:

_____

_____

_____

_____

Do you or have you ever used tobacco products? □ Yes □ No

If yes, how much? _____ **Date started**: _____ **Date quit:** _____

Do you or have you ever used alcohol? □ Yes □ No

If yes, how many times per month? _____ □ Beer □ Wine □ Liquor

PATIENT LAST NAME _____ **FIRST NAME**_____**DOB**_____ **GENDER**_____

ADDRESS_____**CITY/STATE/ZIP**_____**PHONE**_____

Approximately how much money do you spend on **prescription** medication each month? _____

Approximately how much money do you spend on **non-prescription** medication each month? _____

Please list all pharmacies that you use for prescription medications:

Pharmacy Name	**Pharmacy Phone Number**	**Pharmacy Address**

Please list all Medical Providers
(Physician, Nurse Practitioner, Physician Assistant, Dentist, Doctor of Osteopathy, etc.)

Provider Name	**Date Last Seen**	**Provider Name**	**Date Last Seen**

PRIOR AUTHORIZATION NUMBER:_____

Montana PharmAssist Invoice
INITIAL CONSULTATION

Please complete the highlighted areas of this invoice and include the documentation detailed below

NPI#	**Invoice Date:** / /

Pharmacist:	**Submit Invoice and Documentation to:**
Address: **Phone Number: (406) -**	Mountain-Pacific Quality Health Attn: Montana PharmAssist 3404 Cooney Drive Helena MT 59602

Patient Name:

CPT Code	Service Description	Service Date	Start and End Time	Units Billed	Amount Billed
99605	New Patient Initial MTMS (15 minutes)			1	$50.00
99607	Additional MTMS (15 minutes/unit @ $25 ea.)				

Invoice Total $_____
(Max Allowed is $125)

☐ Completed Packet pages.
☐ Copy of recommendation letters and Care Plan for patient and healthcare provider(s).
☐ Recommend Follow-up? (Must be included in Care Plan) Yes ☐ No ☐

Provider/Contractor Approval:	MPQH Approval :
I certify that the amount/s reflected on this invoice represent services actually furnished, that the individuals were eligible to receive said services and that payment has not been received. _____ _____ Pharmacist Signature Date	Approved Amount $ _____ Approved by _____ Follow-up Authorized: Yes ☐ No ☐ Date: _____

DPHHS Payment Processing:
_____ Amount _____Signature _____Date_____