DPHHS-SLTC-149
(Rev. 1/18)

STATE OF MONTANA
Department of Public Health and Human Services

BIG SKY WAIVER
REQUEST FOR PRIOR AUTHORIZATION FORM

NAME_____
MEDICAID #_____ SERVICE PLAN TIME PERIOD _____

TYPE OF REQUEST	COST/ TOTAL HOURS	COST SHEET ATTACHED
● Increase to CC3 Cost Plan	_____	_____
● Environmental Accessibility Adaptions	_____	_____
● Vehicle Modifications	_____	_____
● Service Plan Over Cost Limit	_____	_____
● Specialized Medical Equipment	_____	_____
● Wait Slot Request for Child under 21	N/A	_____
● Amendment to a Prior Authorization	_____	_____
● Out-of-state Non-Medical Transportation	_____	_____
● Non-Medical Transportation	_____	_____
● Social Supervision	_____	_____
OTHER _____	_____	

III. NARRATIVE REQUEST AND JUSTIFICATION

_____
_____
_____

_____ _____ _____
Case Manager **Phone** **Date**

RPO ☐ Concur Do not concur

COMMENTS:_____
_____

_____ _____
Regional Program Officer **Date**

Community Services Bureau ☐ Concur ☐ Do not concur

COMMENTS:_____
_____
_____

Community Services Bureau **Date**

Distribution: Case Management Team; Regional Program Officer; Community Services Bureau