(Rev. 08/16) SLTC-124

STATE OF MONTANA
Department of Public Health and Human Services
Home Health Request for Initial Prior Authorization and Amendment Form

Member Name: _____ **DOB:** _____

Address: _____ **County** _____

Medicaid #: _____ **Phone:** _____

Passport to Health MD: _____ **Phone:**_____

Requesting Agency: _____ **City:** _____

Agency Contact: _____

Provider Number: _____ **Agency Phone:** _____

TYPE OF PRIOR AUTHORIZATION REQUESTED

_____ **Initial Prior Authorization** **Effective Date of Service:** _____

_____ **Amendment of Initial Prior Authorization**

Please provide the following information if requesting an Amendment of an Initial Prior Authorization:

Initial Prior Auth. Date:_____ **Initial Prior Auth. # :**_____

*****Please attach MD orders and two visit notes for each therapy service before submitting.**

Type of Service	Initial Request - Initial Visits requested	Number of visits used	As of Date	Amended Request - Additional Visits Requested
Skilled Nursing				
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Home Health Aide				

Diagnosis/Comments:

Signature: _____ **Date:** _____ **Phone:** _____

Forms should be submitted to:

Mountain Pacific Quality Health:
3404 Cooney Drive
Helena MT 59602
FAX: 1-800-413-3890 or 1-406-513-1921