

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

Member Name: _____ **DOB:** _____

Address: _____ **County** _____

Medicaid #: _____ **Phone:** _____

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

Requesting Agency: _____ **City:** _____

Agency Contact: _____

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

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

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

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

Type of Service	Initial Extended Service Request	Number of visits used	As of Date	Amended Extended Service Request
Skilled Nursing				
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Home Health Aide				

Diagnosis:

Comments:

I certify that there are no equally effective, least costly services available to meet this member's home health needs.

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