DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Part 1 - REQUEST FORM
Goal 189 – Individual Specialized Services

Complete and Secure File Transfer to: CrisisServices@mt.gov

PROVIDER INFORMATION

Request Date: _____
Provider: _____
Facility Name: _____
Facility Address: _____
Phone: _____

CLIENT INFORMATION

Client Name: _____
SSN: _____
DOB: _____
Modified Adjusted Gross Income* (MAGI): _____
Primary Diagnosis: _____
Discharge Date from Crisis Facility: _____
Crisis Facility Name: _____
Reason for request and desired outcome(s) – Include individualized goals:

**To calculate MAGI, use the following form:* Financial Information Form

FUNDS REQUESTED	START DATE	END DATE	COST
[select request type]			
[select request type]			
[select request type]			
[select request type]			
[select request type]			
[select request type]			
TOTAL REQUESTED			$ 0.00

SUBMITTER INFORMATION

Name: _____
Email: _____
Phone: _____

SEND REQUEST TO:

BHDD Treatment Bureau using the State of Montana's Electronic File Transfer System (https://transfer.mt.gov/) to the following email address: CrisisServices@mt.gov

If you have any questions, please email CrisisServices@mt.gov or call (406) 444-3964.

BHDD USE ONLY

Total amount approved: _____

Approval Signature: _____ Date: _____
BHDD Staff Name: _____

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Part 2 – PAYMENT CONFIRMATION
Goal 189 – Individual Specialized Services

Complete and Secure File Transfer to: CrisisServices@mt.gov

INSTRUCTIONS: Complete the following, Part 2 – Payment Confirmation Form, only after receiving written BHDD approval of Part 1 – Request Form.

FUNDS REQUESTED	START DATE	END DATE	COST
[select request type]			
Description:			
[select request type]			
Description:			
[select request type]			
Description:			
[select request type]			
Description:			
[select request type]			
Description:			
[select request type]			
Description:			
TOTAL REQUESTED			$ 0.00

I CERTIFY THAT THIS CLAIM IS CORRECT AND JUST IN ALL RESPECTS, AND THAT PAYMENT OR CREDIT HAS NOT BEEN RECEIVED.

Submitter Signature: _____ Date: _____
Signor Name: _____

SEND THIS FORM, RECIEPTS, AND INVOICES TO:

BHDD Treatment Bureau using the State of Montana's Electronic File Transfer System (https://transfer.mt.gov/) to the following email address: CrisisServices@mt.gov

If you have any questions, please email CrisisServices@mt.gov or call (406) 444-3964.

BHDD USE ONLY

Total Amount Approved: _____
Number of units: _____
Service Start Date: _____ Service End Date: _____
MED ID: _____
Client ID: _____
NPI: _____
PID: _____
Procedure Code: _____Modifier:_____
Taxonomy Code: _____
Provider Type: _____
Prior Authorization Code: _____
Primary Diagnosis: _____

Approval Signature: _____ Date: _____
BHDD Staff Name: _____

In order to receive payment for the approved services, providers must include the procedure code **AND modifier on the claim form.*

Revised September 2024