MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Applied Behavior Analysis (ABA) Services
Provider Transfer Request

Please complete the form in its entirety and send via the secure Montana File Transfer Service at https://transfer.mt.gov to DDPServiceRequest@mt.gov.

Member Information

Member Name _____

Date of Birth _____

Medicaid Card ID _____

Provider Information

Agency Name and Contact Person _____

Telephone Number _____

Email Address _____

Current Authorization Information

Current Authorization Start and End Dates _____

Prior Authorization Number (if applicable) _____

Number of Units Used _____

Authorization Transfer Request

The end date of the amendment will be the same as the current authorization end date.

Anticipated Date of Requested Transfer _____

☐ This transfer is requested to split hours of the current authorization with another provider.

OR

☐ This transfer is requested to transition the entire amount of the current authorization to the provider requesting this change.

Justification for Transfer

_____

_____

Signatures

Both the original provider **and** additional provider must sign this amendment.

ORIGINAL Authorized Provider Printed Name _____

Signature and Credentials _____ **Date** _____

ADDITIONAL Requested Provider Printed Name _____

Signature and Credentials _____ **Date** _____

PARENT / LEGAL GUARDIAN Printed Name _____

Signature _____ **Date** _____

☐ I agree to have the member's Assessment & Clinical Treatment Plan and Implementation Plans released to my new provider (if applicable).