# Request for Blanket Denial Letter

## State of Montana Medicaid

Effective Date Requested _____ Provider/NPI _____

Member Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____

2. _____

3. _____

4. _____

5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

**Fax all requests to 406-442-0357.**

**Request must include an explanation of benefits (EOB) stating the services are not covered.**