Sample

DPHHS-HCS-782
(Rev. 1/13)
Page 1 of 2

STATE OF MONTANA
Department of Public Health and Human Services
Human and Community Services Division

COUNTY USE ONLY: Case No. _____

MEDICAID SERVICES ESSENTIAL FOR EMPLOYMENT

NAME: _____ SOCIAL SECURITY NUMBER: _____
(Please Print)

INSTRUCTIONS:
→ The Medicaid recipient/case manager is to complete sections (1) and (3), then sign and date the ... w secti...
Medicaid Recipient does NOT complete shaded sections.
→ The Medicaid provider is to complete section (2) below, then sign and date that section in th... ide...
→ **A separate form must be completed for each service requested.**

REQUEST REQUIREMENTS

1. **EMPLOYABILITY:** *(To be completed by **MEDICAID RECIPIENT/CASE MANAGER**)*
Briefly describe why this service is needed to seek, obtain or maintain employment: _____

List name and address of employer (if working): _____
Date employment/job search started/will start: _____
Average weekly hours worked/seeking employment **(attach verificat...** _____
Is this employment temporary? If yes, when is it expected to end... _____
If employed, please list your major job duties (i.e., greeting the ...veri... ...hone, operating machinery, filling orders, etc.) _____

2. **MEDICAL:** *(To be completed by **MEDICAID PROV...***
List medical service required: **(Attach specific ...des and ...plan, if possible)** _____

Medicaid provider name **(please p...** _____
Medicaid provider signature: _____ Date: _____

IF APPROVED, RE... ...EMEN... ...E AT REGULAR MEDICAID RATES
► **INDIVIDUAL MU... BE RECEIVING ...AID AT THE TIME OF SERVICE, OR CLAIM WILL BE DENIED**

3. **RESOURCES EX... ...pleted by ...EDICAID RECIPIENT/CASE MANAGER)**
Please list other re... y... ...to obtain this medical service (i.e., have you contacted your county public health department? Lion's ...ocatio... ...?): _____

► ...ams, x-rays a... ...gs are not covered by the Essential for Employment program.
...eyeglass... ...prescrib... ...must be selected through and billed by Walman. **If eyeglasses are not selected through ...and ...n, th... ...dicaid Recipient will be responsible to pay for the eyeglasses.**

...e inform... ...have provided on this form is true and correct to the best of my knowledge.
Medicaid Re... ...ature: _____ Date: _____

I have revie... ...is form and the attached verification. Alternative community resources have been explored with the recipient.
County Director or Designee Signature: _____ Date: _____
*** Unsigned forms will be returned to the County Office.**

Submit form, along with the required verification, to Screening Committee for review.
Policy & Systems Bureau, P.O. Box 202925, Helena, MT 59620-2925

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SCREENING RESULTS

NOTE: ***In order for this service to be covered by Medicaid, the individual must be receiving Medicaid at the t[illegible] the service(s) is rendered, all three sections below must be marked as approved, and all must be sign[illegible] dated. Incomplete forms or the individual not receiving Medicaid at the time of service will result in M[illegible] not covering the service(s).***

4. **REVIEW OF "ESSENTIAL FOR EMPLOYMENT" CRITERIA:** *(To be completed by **POLICY & SYS[illegible]***

Policy & Systems Bureau (PSB): APPROVES: _____ DENIES: _____ this request.

Explanation of approval or denial: _____

PSB Signatures and Titles: (a) _____

(b) _____

5. **REVIEW OF COVERAGE:** *(To be completed by **MEDICAID [illegible]***

The requested service is: APPROVED: _____ DENIED [illegible]dicaid coverage.

Explanation of approval or denial: _____

Signature(s): _____ Date: _____

_____ Date: _____

6. **AUTHORIZATION:** *(To be completed [illegible]**CY & [illegible]UREAU)***

Authorization is: APPROVED: _____ [illegible]D: _____

Signature: _____ Date: _____

(Policy & Sys[illegible]

If approved, this authoriz[illegible]ill on[illegible]verride the benefit restrictions that apply to Basic Medicaid recipients. **ALL OTHER PROGRAM LIMITATION[illegible]PRE-A[illegible]N REQUIREMENTS STILL APPLY.**

MEDICAID PROVIDER: T[illegible]n is valid for a maximum of 180 days, and only if the individual is receiving Medicaid at the time the ser[illegible]endered. A[illegible]f services completed more than 180 days after the approval date, or while the individual is not rec[illegible]aid <u>will be den[illegible]</u> ntact XEROX to verify eligibility prior to performing any procedure or before each vi[illegible]a servic[illegible]

di[illegible] take[illegible]e approved form to Medicaid provider. Provider should retain a copy in his/her files.

M[illegible] PROVID[illegible]TTACH PINK COPY OF APPROVED FORM TO CLAIM AND SUBMIT TO:

MEDICAID SERVICES, PO BOX 202951, HELENA, MT 59620-2951

Claims sent directly to XEROX will be denied

ATTACHMENTS: Supporting documentation to justify medical need of the requested item must accompany this form. Documentation includes, but is not limited to a prescription, Certificate of Medical Need (if required) and the patient's primary care provider's narrative description detailing need for the item. If being treated by a licensed therapist, a copy of the patient's plan of care and narrative summary supporting the request are required.