DPHHS-SLTC-124
(Rev. 05/05)

STATE OF MONTANA
Department of Public Health and Human Services

HOME HEALTH SERVICES
REQUEST FOR INITIAL AUTHORIZATION

Recipient Name: _____ **DOB:** _____

Address: _____ **County** _____

Medicaid #: _____ **Medicare #:** _____

Is this recipient under Passport? _____ **Passport MD:**_____ **MD Phone:**_____

Requesting Agency: _____ **Contact:** _____

Provider Number: _____ **City:** _____ **Phone:** _____

Date services to be initiated: _____

Does the recipient have primary insurance coverage: _____

_____

_____

Has service been denied from primary insurer (provide copy): _____

_____

_____

Diagnosis: _____

_____

_____

_____

If dually eligible, in detail explain why recipient does not qualify for the Medicare benefit: _____

_____

_____

Type of prior authorization requested (July to June):

_____ **To provide 1 - 75 skilled nursing visits per state fiscal year.**

_____ **To provide 1 - 100 combined therapy (PT, ST, OT) visits per state fiscal year.**

_____ **To provide _____ home health aide visits.**

Synopsis of services (includes frequency, duration and anticipated outcome):

Signature: _____ **Date:** _____ **Phone:** _____

FOUNDATION USE ONLY

Approved _____ **Denied** _____

Comments:

Reviewer Signature: _____ **Date:** _____

Note: If services in excess of above limits are required, prior authorization must be requested from the Mountain Pacific Quality Health Foundation on form DPHHS-MA-125, Request for Prior Authorization for Extended Services.

Fax all Home Health requests to: 1-800-413-3890