

Montana Medicaid or Healthy Montana Kids (HMK) Prior Authorization Request

Eyeglass Additional Feature and Contact Lens

To facilitate prompt and accurate processing, the information below must be complete and any additional information for this request must be submitted with this form.

Today's Date _____

Member Information				
Last Name	First Name	MI	Member ID	Date of Birth
Service Type. Check all that apply.				
☐ Photochromatic (transition)	☐ Polycarbonate	☐ Contact lens exam/fitting	☐ Tint other Rose 1 or 2	
☐ Deluxe Frame	☐ Fresnel Prism, press on	☐ Contact lens supply	☐ 2 pair eyeglasses	
Procedure Code, if applicable.				
Procedure Code if applicable.				
Date of Visit or Procedure				
Pay-To Provider Information				
Provider Name		Provider NPI		
Rendering Provider Information				
Provider Name		Provider NPI		
Prior Authorization Submitter Contact Information				
Contact Name	Telephone	Fax		
Additional Information for medical necessity (required)				