Addictive and Mental Disorder Division
Mental Health Per Day Limit Exception Form
All forms must be typed. Handwritten or incomplete forms will be returned.

Exceptions are issued for 90 days. Submit a new Exception Request no sooner than 5 business days prior to the end of the current exception period.

Start Date: _____

Requested Services:

☐ **Day treatment** **How many Units per day Requesting:** _____

☐ **Community Based Psychiatric Rehabilitation and Supports** **How many Units per day Requesting:** _____

Provider Information

Provider Name: _____ Provider ID: _____
Address: _____ City: _____ Zip: _____
Phone # _____ Fax # _____

Demographics

Member Name: _____ Birthdate: _____ Medicaid # _____
Address: _____ City: _____ Zip: _____
Phone # _____ Cell # _____ SS # _____

Does member have legal guardian/power of attorney? ☐ Yes ☐ No

Guardian Name: _____ Relationship to member: _____
Address: _____ City: _____ Zip: _____
Phone # _____ Cell # _____

Exception Criteria/Medical Necessity: *Complete all requests for information below*

Does the member meet the SDMI Criteria? ☐ Yes ☐ No

Current SDMI Diagnosis: _____ Current LOI Score: _____

Describe the recent symptoms/issues requiring additional services (provide details, including dates of recent occurrence, frequency, duration, and severity over the last 30 to 45 days.)

Describe the mental health needs that can't be met without the requested additional services.

How Will the requested service help the member achieve the individualized goals and outcomes in the member's treatment plan?

Fax Completed Form to
AMDD Secure Fax: 406-444-4435
If you have any questions, please contact AMDD at
HHSAMDDUtilizationReview@mt.gov.

Do not send PHI or HIPPA protected information through email

Office use only

☐ Approved ☐ Denied Begin Date: _____ End Date: _____

Number of Units Per Day Approved: _____ Reason: _____

Reviewer's Signature: _____ Date: _____

Print Form **Save Form** **Reset Forms**