STATE OF MONTANA
Department of Public Health and Human Services

BIG SKY WAIVER
TERMINATION OF COVERAGE – PROVIDER NOTIFICATION

FAX TO: Mountain Pacific Quality Health (MPQH)

Name ______________________________ ______________________________
(Last) (First)
Medicaid ID Number ______________________________
CMT/IA Provider Number ______________________________
Most Recent Admit Date ______________________________
Termination Date ______________________________
(Termination Date must be the same date listed on MA-55)

- ◻ Member's Death
- ◻ Nursing Home Placement
- ◻ Medicaid Hospital Placement
- ◻ No Longer Requires Services
- ◻ Medicaid Ineligibility
- ◻ Moved from Service Area
- ◻ Exceeded Cost Limit
- ◻ Voluntary Termination
- ◻ Other (Specify): ______________________
- ◻ No Longer Meets Level of Care

Provider Name/Notification Information	**Date**

______________________ ______________________ ____________
Name **Case Management Team** **Date**