(Rev. 08/16, 02/19) SLTC-124

STATE OF MONTANA
Department of Public Health and Human Services
Home Health Request for Initial Prior Authorization and Amendment Form

Member Name: _____ **DOB:** _____
Address: _____ **County** _____
Medicaid #: _____ **Phone:** _____
Ordering Physician: _____ **Phone:**_____
Requesting Agency: _____ **City:** _____
Agency Contact: _____
Provider NPI Number: _____ **Agency Phone:** _____

TYPE OF PRIOR AUTHORIZATION REQUESTED

_____ **Initial Prior Authorization** **Effective Date of Service:** _____

_____ **Amendment of Initial Prior Authorization**

Please provide the following information if requesting an Amendment of an Initial Prior Authorization:

Initial Prior Auth. Date:_____ **Initial Prior Auth. # :**_____

NOTE: **For initial prior authorization requests, this form must be accompanied by a current, signed Home Health Certification and Plan of Care form (SLTC 126).**

For amendments to the initial prior authorization, this form must be accompanied by two nursing visit notes and a current, signed Home Health Certification and Plan of Care form (SLTC 126) if more than 60 days as elapsed since the last physician certification date.

Type of Service	Initial Request - Initial Number Of Visits Requested	Number Of Visits Used	Date Last Visit Of Current Authorization Will Be Used	Amended Request - Additional Number Of Visits Requested
Skilled Nursing				
Occupational Therapy				
Speech Therapy				
Physical Therapy				
Home Health Aide				

Diagnosis/Comments:

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

Forms should be submitted to:

Mountain Pacific Quality Health:
3404 Cooney Drive
Helena MT 59602
FAX: 1-800-413-3890 or 1-406-513-1921