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

Member Name: _____ **DOB:** _____

Address: _____ **County** _____

Medicaid #: _____ **Phone:** _____

Ordering Physician: _____ **Phone:**_____

Requesting Agency: _____ **City:** _____

Agency Contact: _____

Provider NPI Number: _____ **Agency Phone:** _____

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

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

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

Diagnosis:

Comments:

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

NOTE: This form must be accompanied by the most recent Home Health Certification and Plan of Care form (SLTC 126) and copies of at least two nursing/therapy notes before prior authorizations for extended home health services will be granted.

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