Montana Medicaid Adult Data Corrections Request Form
Correction to Adult Information

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

DATE OF REQUEST: _____

REQUEST TYPE: ☐ Med/Surg ☐ Behavioral Health ☐ PASRR ☐ ADHC

Provider Information			
FACILITY NAME:		**FACILITY'S MEDICAID NUMBER:**	
CONTACT NAME:	**PHONE NUMBER:**	**EXTENSION:**	**FAX NUMBER:**

Description of the Problem:

Provider's Justification (Mandatory):

Beneficiary Information		
PAITIENT NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**
DATE OF BIRTH:	**ADMISSION DATE:**	**DISCHARGE DATE:**

Prior Authorization Information	
PRIOR AUTHORIZATION NUMBER:	**REQUEST ID NUMBER:**

Magellan Medicaid Administration's Use Only	
NURSE OR CCS ASSIGNED:	
DATE CORRECTION DETERMINATION:	
SIGNATURE:	**DATE:**

To transmit request information:
Fax: 1-800-639-8982
Phone: 1-800-770-3084