Montana State Hospital Prior Authorization Request Form

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

Patient Information				
NAME:				
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**
DOB:	**MEDICAID NUMBER:**	**SSN:**	**ADMIT DATE:**	
GENDER: ☐ Male ☐ Female				

Responsible Party Information (if other than patient)			
NAME:	PHONE NUMBER:		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
RELATIONSHIP TO PATIENT: ☐ Self ☐ Other:			

Admitting Facility Information			
NAME:			
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PHONE NUMBER:	**FAX NUMBER:**	**ESTIMATED LENGTH OF STAY:**	
PROVIDER NUMBER:	**NPI NUMBER:**	**TAXONOMY:**	

Clinical Information	
DSM V DIAGNOSIS:	
CODE:	**DESCRIPTION:**
CODE:	**DESCRIPTION:**
CODE:	**DESCRIPTION:**
CODE:	**DESCRIPTION:**
CODE:	**DESCRIPTION:**

Summary of Current Psychological Symptoms, Behavior, and Level of Functioning:

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

Current Medications:		
Type of Medication	**Dosage**	**Start/End/Change Date (REQUIRED)**

Treatment Plan:

Previous Inpatient Treatment (Please describe.):

DOES THE PATIENT HAVE A CASE MANAGER? ☐ Yes ☐ No
CASE MANAGER NAME:
CASE MANAGEMENT PROVIDER:

Discharge Plan (Please include estimated date of discharge.):

ASSESSMENT COMPLETED BY:

TITLE: **DATE:**

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