Montana Medicaid Youth Data Corrections Request Form

Correction to Youth Information

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

DATE OF REQUEST:

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

Description of the Problem:

Requested change or correct information:

Youth Information		
YOUTH NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**
DATE OF BIRTH:	**ADMISSION DATE:**	**DISCHARGE DATE:**

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

Magellan Rx Management 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