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.

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| Date of Request:  |       |
| Request Type:  | [ ]  Med/Surg | [ ]  Behavioral Health | [ ]  PASRR | [ ]  ADHC |

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| Provider Information |
| Facility NAME:      | Facility’s medicaid number:      |
| contact name:      | Phone Number:      | Extension:      | Fax Number:      |

| Description of the Problem: |
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|       |

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| Provider’s Justification (Mandatory): |
|       |

| Beneficiary Information |
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| Paitient NAME:      | Medicaid Number:      | Social Security Number:      |
| Date of birth:      | Admission Date:      | Discharge Date:      |

| Prior Authorization Information |
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| Prior authorization number:      | Request ID Number:      |

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| Magellan Medicaid Administration’s Use Only |
| Nurse or CCS Assigned: |
| Date Correction Determination: |
| Signature: | Date: |