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

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