Montana State Hospital Prior Authorization Request Form

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

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| Patient Information |
| NAME:      |
| ADDRESS:      | CITY:      | STATE:   | ZIP:      |
| DOB:      | MEDICAID NUMBER:      | SSN:      | ADMIT DATE:      |
| GENDER: | [ ]  Male | [ ]  Female |

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

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

| Clinical Information |
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| DSM V DIAGNOSIS:  |       |
| Code:  |       | description:  |       |
| Code:  |       | description: |       |
| Code:  |       | description:  |       |
| Code:  |       | description:  |       |
| Code:  |       | description:  |       |

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

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

| Treatment Plan: |
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|       |

| Previous Inpatient Treatment (Please describe.): |
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|       |

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| Does the patient have a case manager? [ ]  Yes [ ]  No |
| Case Manager Name:  |       |
| Case Management PROVIDER:  |       |

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

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| Assessment Completed By:  |       |
|  |  |
| Title:  |       |  | Date:  |       |