Mountain Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
(406) 457-3060 (Local)
(877) 443-4021 (Toll-free)
(406) 513-1923 (Local Fax)
(877) 443-2580 (Long Distance Fax)

Montana Medicaid

Medical-Surgical Prior Authorization Request

This form is to be used for all providers in a single case. To facilitate prompt and accurate processing, the information below must be complete and all supporting clinical documentation related to this request must be submitted with this form.

Today's Date

Section A		
Last Name First Name MI	**Medicaid ID**	**Date of Birth**

Service Type - Check all that apply.		Provider Type - Mark all applicable provider types
☐ Inpatient	☐ In State	☐ Performing or Rendering Provider
☐ Outpatient	☐ Out of State	☐ Hospital
		☐ Ambulatory Surgical Center

Section B. Rendering Provider Information- Fill this section out for ALL performing providers including assistant surgeons, if needed. If additional space is needed, please use Additional Information field below.

Provider Name	Procedure Code and Modifier, if applicable	Provider Name	Procedure Code and Modifier, if applicable
	Procedure Code and Modifier, if applicable		Procedure Code and Modifier, if applicable
Provider NPI (NOT TIN)	Procedure Code and Modifier, if applicable	**Provider NPI (NOT TIN)**	Procedure Code and Modifier, if applicable
	Procedure Code and Modifier, if applicable		Procedure Code and Modifier, if applicable

Date of Visit or Procedure Or, if unknown, check here.	Diagnosis

Section C. Facility Information – Fill this information on the facility where the services will be provided (Only complete if you know what codes the facility will be billing for)

Facility Name and Fax Number	Procedure Code and Modifier, if applicable
	Procedure Code and Modifier, if applicable
Facility NPI (NOT TIN)	Procedure Code and Modifier, if applicable
	Procedure Code and Modifier, if applicable

Prior Authorization Submitter Contact Information		
Contact Name	**Telephone**	**Fax**

Additional Information