DPHHS-SLTC-125
(Rev. 05/05)

STATE OF MONTANA
Department of Public Health and Human Services

HOME HEALTH SERVICES
REQUEST FOR PRIOR AUTHORIZATION
FOR EXTENDED SERVICES

Recipient Name: _____ **DOB:** _____

Address: _____ **County** _____

Medicaid #: _____ **Medicare #:** _____

Is this recipient under Passport? _____ **Passport MD:** _____ **MD Phone:** _____

Requesting Agency: _____ **Contact:** _____

Provider Number: _____ **City:** _____ **Phone:** _____

Date services were initiated _____ **Original PA #** _____

Type of prior authorization requested:

_____ **To provide additional skilled nursing visits.** **# of Visits Used**___ **As of** _____ **Additional requested** _____

_____ **To provide additional therapy visits.**

		# of Visits Used	As of	Additional requested
Type of service	**OT**	_____	_____	_____
	PT	_____	_____	_____
	ST	_____	_____	_____

_____ **To provide additional aide visits** **HHA** _____ _____ _____

Synopsis of services (includes frequency, duration and anticipated outcome):

Signature: _____ **Date:** _____ **Phone:** _____

FOUNDATION USE ONLY

_____ **Approved** _____ **Denied**

_____ **Comments:**

Reviewer Signature: _____ **Date:** _____

Instructions: **Agency: Complete form in full, indicating total number of additional visits being requested.**

Fax all Home Health requests to: 1-800-413-3890.