## **Mountain-Pacific Quality Health Foundation**

## **Request for Medicaid Home Infusion Therapy Authorization**

Home IV										
Contact Person						Please Type or Print				
Patient Name:(Last), (First) (MI)				Medicaid Number			Date of Birth			
Physician Name				City, State ZIP			Phone Number Fax			Fax Number
Provider # Provider Name				Phone Nu		imber Fax 1			umber	
Street Address				City			State ZIP			
Date Therapy Initiated:				Is this an extension of an existing PA? Yes No						
Pertinent Information: (C&S, chart notes, etc)  Attached?										
Diagnosis: Additional Comments:										
SERVICES TO BE AUTHORIZED  From Thru Procedure Modifier Days Therapy										
1.	1 IIru	rrocedure	Mounter	Days	Тистару					
2.										
3.										
4.										
5.										
DRUG PRIOR AUTHORIZATION Mountain-Pacific Quality Health Four 3404 Cooney Drive HELENA, MT 59602 (406)443-6002 or 1-800-395-7961 (PH (406)443-7014 or 1-800-294-1350 (F									lth Foundation ve 602 961 (PHONE)	
LEAVE BLANK - PA UNIT USE ONLY										
REASON FOR DENIAL OF THERAPY PRIOR AUTHORIZATION										
IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient contines to be eligible for Medicaid. It is the responsibility of the provider of service to establish of the recipient's Medicaid eligibility.										
CURRENT REC	IPIENT ELIGIBILIT	Y MAY BE VERI	IFIED BY CAL	LLING ACS	AT 1-800-6	24-3958 or 40	06-442-18	837		
Approval / Denial Status	Approve/Deny Code	Therapeu	utic Class		Auth.ID	Date of	Request Prior Authorization Number			