MISSOULA COUNTY EMPLOYEE BENEFITS PLAN

Mailing Address: 200 West Broadway
Physical Address: 223 West Alder Street
Missoula, MT 59802-4292

P: 406.258.4876 | F: 406.258.4731
E: benefits@missoulacounty.us

Missoula COUNTY

Prior Authorization Request Form

Claims will be processed according to all plan provisions on the date of service including but not limited to eligibility, deductible, out of pocket amounts, discounts, and allowed amounts. Treatment must be medically necessary and not experimental or investigational.

Provider information:

Servicing provider name: _____ Specialty: _____

Tax ID number: _____ NPI: _____

Phone number: _____ Fax number: _____

Contact Person: _____

___ Check here for a peer-to-peer
Peer-to-peer availability:
Date: _____Time: _____
Date: _____Time: _____

Member Information:

Patient Name: _____ DOB: _____
Health Insurance ID#: _____

Diagnosis/Planned Procedure Information

*Principal Diagnosis Description: _____
ICD-10 Codes: _____ CPT/HCPCS Code: _____
Billed amount for Procedure # 1 _____
# of units requested:
____ Hours ____ Days ____Months ____Visits ____Dosage

*Secondary Diagnosis Description: _____
ICD-10 Codes: _____ CPT/HCPCS Code: _____
Billed amount for Procedure # 2 _____
# of units requested:
____ Hours ____ Days ____Months ____Visits ____Dosage
Service Start Date: _____

*If you are requesting prior authorization for a drug, please indicate if this is going to be self-injectable.
Yes_____ No_____
If the drug is going to be self-injectable, prior authorizations must be submitted to the pharmacy benefit manager, Medimpact. Phone: 1-800-788-2949 Fax: 858-790-7100, forms can be found at https://www.medimpact.com/Prior-Authorization-Forms

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Signature: _____

Date Form Completed and Faxed/emailed: _____

Submit this form along with supporting documentation to benefits@missoulacounty.us or via fax at 406-258-4731