

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 ☐

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C O U N T Y

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>

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