Mountain-Pacific Quality Health | Telligen | Montana DPHHS

Montana Medicaid Form

Youth Continued Stay Request Authorization Form
Psychiatric Residential Treatment Facility (PRTF)

* This form can also be completed and submitted via the provider portal (https://www.mpqhf.org/corporate/medicaid-portal-home/).

Requester – Recommended the requester is a licensed mental health professional but not required. *NOTE: All fields must be legible to avoid a delay in processing and admission.		
Name and Credentials:		
Phone:	Fax:	
Youth Information		
Name:	SSN:	
Medicaid Number:	Admission Date:	
Address:	City:	
State:	Zip Code:	Phone:
Responsible Party *This is the party who receives notifications and is authorized to consent for medical treatment (CPS worker or probation officer when applicable).		
Name:		
Address:	City:	
State:	Zip Code:	Phone:
Relationship to Youth:		
Facility Information		
Name:	NPI Number:	
Address:	City:	State:
Zip:	Phone:	Fax:
Start Date:	Numbers for Days Requested:	
Clinical Information		
☐ Any changes in DSM V Diagnosis: ☐ Code and Description: ☐ Code and Description:		
Date of Physician's Initial Admission Assessment by Facility:		

*Send PRTF Certificate of Need with this form.

For Internal Use by Mountain-Pacific or Telligen Staff Only	
☐ Date Approved: ☐ Date Denied:	☐ Through: ☐ Through:
Signature:	Date:

Phone: 1-800-219-7035 • Fax: 1-833-574-0650

Please note this is ONLY required if faxing the authorization request through February 28, 2020. If submitting via the provider portal (https://www.mpqhf.org/corporate/medicaid-portal-home/), this form is not required.