DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-019

2. STATE: Montana

3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2012

5 TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
N/A

7. FEDERAL BUDGET IMPACT.
a. FFY 2011 $ 0
b. FFY 2012 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Page(s) 1 of 1 and 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.b
Optometrists' Services

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page(s) 1 of 1 and 2 of 2
Attachment 4.19B
Methods & Standards for Establishing Payment Rates
Service 6.b
Optometrists' Services

10. SUBJECT OF AMENDMENT:
Amend Service 6b, Optometrist service to update the dates and rates on the fee schedule.

11 GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15 DATE SUBMITTED: 6/22/12

16. RETURN TO
Montana Dept. of Public Health and Human Services
Mary E. Dalton
State Medicaid Director
Attn: Jo Thompson
PO Box 4210
Helena, MT 59604

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/22/12

18. DATE APPROVED: 9/19/12

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/12

20. [redacted] OFFICIAL:

21. TYPED NAME: RICHRD C. ALLEN

22. TITLE: ARA, DMCHO

23. REMARKS: