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: 12-020

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
July 1, 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:

7. FEDERAL BUDGET IMPACT
a. FFY 2012 $0
b. FFY 2013 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT.
Service 5a Physician Services
Attachment 4 19B, Pages 1 and 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Service 5a Physician Services
Attachment 4.19B, Pages 1 and 2

10. SUBJECT OF AMENDMENT:
Amend Service 5a Physician Services to update fee schedule. Notice of Public Hearing on Proposed Amendment, MAR Notice No. 37-582.

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: SINGLE AGENCY DIRECTOR REVIEW

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: **State Medicaid Director**

15. DATE SUBMITTED: 6/22/2012

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: 7/1/12

PLAN APPROVED - ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: RICHARD C ALLEN

22. TITLE: ARA, DMCHO

23. REMARKS: