Print Form

UTAH DEPARTMENT OF HEALTH
DIVISION OF MEDICAID AND HEALTH FINANCING

1-800-662-9651 toll free
(801)538-6155
(801) 536-0970 Fax

RETROACTIVE AUTHORIZATION NURSING FACILITY REQUEST FORM

CLIENT INFORMATION

10-A DOCUMENT NUMBER | LAST NAME | FIRST NAME

DATE OF BIRTH | MEDICAID ID | FACILITY ADMISSION DATE | MEDICAID ADMISSSION DATE

HAVE MEDICARE DATES BEEN UTILIZED

☐ NO ☐ YES (provide dates)

FROM | TO

SINCE ADMISSION, HAS THE RESIDENT BEEN ADMITTED TO THE HOSPITAL FOR MORE THAN 3 DAYS

☐ NO ☐ YES (provide dates)

FROM | TO

REASON FOR RETROACTIVE AUTHORIZATION REQUEST

☐ MEDICARE DAYS DENIED (If denied attach a copy of the denial letter)

☐ Request that the Medicaid clinical eligibility date correspond with the financial eligibility date (Attach a copy of the financial eligibility approval letter)

☐ FACILITY ERROR (Select one)

- ☐ AFTER HOURS ADMISSION
- ☐ FAILED TO SEND 10A
- ☐ PRIVATE INSURANCE
- ☐ WEEKEND/HOLIDAY ADMISSION
- ☐ MISCALCULATED HOSPITAL READMISSION TIMEFRAME

What policies and procedures have been implemented to prevent this from occuring in the future?

THE FOLLOWING DOCUMENTS ARE REQUIRED TO BE SUBMITTED WITH THE RETROACTIVE AUTHORIZATION REQUEST

☐ Physician certification(s) for Nursing Facility Services covering the Medicaid admission date through the request date

☐ History and Physical

☐ Minimum Date Set (MDS) assessment(s) covering the Medicaid admission date through the request date

PROVIDER INFORMATION

NURSING FACILITY

ADMINISTRATOR NAME

ADMINISTRATOR SIGNATURE | PHONE NUMBER | DATE

STATE USE ONLY

DATE RECEIVED

☐ **DENIAL** ☐ PASSR ☐ GREATER THAN 90 DAYS ☐ INCOMPLETE APPLICATION ☐ GREATER THAN FINANCIAL APPROVAL

☐ **APPROVED** CURRENT EFFECTIVE DATE | NEW EFFECTIVE DATE | DAYS USED

APPROVED/DENIED BY