Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid
Hospice Admission Record Submission

Instructions

- Please note that Hospice Admission Records can be submitted online at https://prism.health.utah.gov
- Complete this form fully and legibly. All fields marked with an asterisk (*) are required
- Submit the completed form along with all clinical documentation to the fax or email address below
- For questions, call (801) 538-6155 or toll free (800) 662-9651 and select options 3, 3, 8

FAX: 801-536-0162 **EMAIL:** fax_allotherauth_prior@utah.gov

Beneficiary Information	
Name: *	Medicaid ID #: *
Provider Information	
Requesting Provider: *	
Today's Date: *	NPI: *
Admission/Enrollment Information	
Effective Date: *	Service Start Date:
Type of Facility: * ☐ Community ☐ Nursing Facility ☐ Residence	
Contact Person: *	Phone Number: *
Attending Physician NPI:	
Is the individual expected to move to community? * ☐Yes ☐ No	
Is the admission likely to be 30 days or longer? * ☐ Yes ☐ No	
Estimated length of stay (in months): *	
Primary Diagnosis Code: *	Secondary Diagnosis Code:
Has this patient already been discharged from this facility? * ☐ Yes ☐ No	
Physician Certification Date: *	Election Date: *
Enhanced Rate Start Date: *	Enhanced Rate End Date: *
Discharge/Disenrollment Information (required if patient has been discharged)	
Type of Discharge/Disenrollment: ☐ Death ☐ Voluntary ☐ Involuntary	
Date of Discharge/Disenrollment:	
Reason:	
Discharge to:	
Name of Facility (if applicable):	
Address:	
Responsible Party Information	
Name:	Phone Number:
Relationship to Patient:	
Address Information	
Address Type: ☐ Home ☐ Responsible Party ☐ Mailing	
Address:	
City, State, Zip:	
Previous Provider/Facility Information	
Previous Service Location: ☐ Home ☐ Hospice ☐ Hospice Residence ☐ Hospital ☐ LTC Facility ☐ Medicaid Health Plan ☐ Other Waiver Agency ☐ Nursing Facility	
Previous Enrollment Date:	Previous Discharge Date:
Provider/Facility Name:	
Provider/Facility NPI:	Phone Number:

Other Insurance Information	
Type of Insurance: ☐ Medicare ☐ Private Health Insurance ☐ Private LTC Coverage	
Insurance Company:	
Policy Number:	
Group Number:	
Policy Holder Employer Name:	
Policy Begin Date:	Policy End Date:
Policy Holder Name:	
Policy Holder SSN:	Policy Holder DOB:
Additional Information	

Certification	
Member Certification	☐ The member has a signed election statement in place *
Member/Authorized Representative Name: *	
Witness Name: *	
Provider Certification	☐ The information entered is, to the best of my knowledge, accurate and complete as of the date this form was completed *
Provider Name: *	