Utah Department of Health & Human Services
Integrated Healthcare

Utah Medicaid Prior Authorization Request Form

Instructions

- Please note that prior authorization requests should be submitted online at https://prism.health.utah.gov/. Prior approval should be received before submitting a PA via fax or email.
- Complete this form fully and legibly. All fields with an asterisk (*) are required.
- Review the entire form to ensure all information for the requested service is completed. Incomplete forms will be returned. Some services require the completion of an additional form. Refer to the Medicaid website to view the required forms.
- Submit the completed form and all supporting documentation to the appropriate fax number or email address below.
- For questions, call (801) 538-6155 or toll free (800) 662-9651 and select options 3, 3, then the appropriate number for the program.
- Dental: FAX: 801-536-0958 | EMAIL: fax_dental_prior@utah.gov
  TAM Dental: FAX: 801-323-1560 | EMAIL: fax_tamdentalservices_prior@utah.gov
  All Other Authorization Requests: FAX: 801-536-0162 | EMAIL: fax_allotherauth_prior@utah.gov

Beneficiary Information

1. Name (First, Middle Initial, Last): *		2. Beneficiary ID#: *
3. Date of Birth: *	4. Age: *	5: Gender: * ☐ Female ☐ Male
6. Is the member in a skilled nursing facility? ☐ No ☐ Yes, Facility Name:		Facility Phone #:
7. Has eligibility been verified? * ☐ No ☐ Yes		
8. Is the member enrolled in a managed care entity (MCE)? * ☐ No ☐ Yes, contact member's MCE		
9. Is the request for a carve out service? * ☐ No ☐ Yes		

Provider Information

10. Requesting Provider: *	11. NPI: *
12. Requesting Provider Address: *	
13. Rendering/Servicing Provider (or Facility): *	
14. Rendering/Servicing Provider NPI: *	
15. Contact Person: *	
16. Fax #: *	17. Phone #: *

Request Information

18. Date of submission: *	19. Requested date(s) of service: * -
20. Original date of admission to treatment center (required for SUD only): *	
21. Is this a retroactive request? * ☐ No ☐ Yes, list reason (Required if "Yes"):	
22. Facility Code Qualifier: B	23. Facility Type Code (see page two): *
24. ICD 10 CM Diagnosis Code: *	

25. CPT or HCPCS code*	26. Code Description*	27. Modifier	28. Units or Visits*	29. Dental Quadrant(s)
1.				
2.				
3.				
4.				
5.				

30. Delivery Pattern* (required for Home Health, PDN, Speech Therapy, Physical Therapy, and Occupational Therapy)

Service Delivery Pattern (e.g., 2 visits per every 3 days for 21 days):
Calendar Pattern (e.g., 1st week of the month, M-F):
Time Pattern (e.g., 1st shift, any shift):

31. Enteral Formula

Kcalories per day:	Percentage of nutrition by tube:
Units = kcals per day ÷ 100 X number of days. If prescribed in flow rate, document calculation used in conversion to kcals per day.	

32. Physical Therapy and Occupational Therapy

☐ Physical Therapy (97010-97136, 97110-97124, 97140-97533)	Number of Visits:	Have PT Limits been met? ☐ Yes ☐ No
☐ Occupational Therapy (97010-97136, 97110-97124, 97140-97533)	Number of Visits:	Have OT Limits been met? ☐ Yes ☐ No

33. Urine Drug Testing

☐ Presumptive test (limited to 8/30-day period)	☐ 80305 ☐ 80306 ☐ 80307
☐ Definitive test (limited to 1/30-day period)	☐ G0480 ☐ G0481 ☐ G0482 ☐ G0483

34. Home Health and PDN* (required for these services)

Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐ Less than 6 months to live ☐ Terminal	
Certification Period: -	Physician Order Date:

Prior authorization does not guarantee reimbursement. All other Medicaid requirements must be met in order for a provider to receive reimbursement. Information contained in this form is Protected Health Information under HIPAA.

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35. Additional Information

36. CPT or HCPCS code	37. Code Description	38. Modifier	39. Units or Visits	40. Dental Quadrant(s)
1.				
2.				
3.				
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Facility Code Qualifier	Facility Type Code	
B. Place of Service Codes for Professional or Dental Services	01. Pharmacy	26. Military Treatment Facility
	02. Telehealth	31. Skilled Nursing Facility
	03. School	32. Nursing Facility
	04. Homeless Shelter	33. Custodial Care Facility
	05. Indian Health Services Free-standing Facility	34. Hospice
	06. Indian Health Services Provider-based Facility	41. Ambulance – Land
	07. Tribal 638 Free-standing Facility	42. Ambulance – Air or Water
	08. Tribal 638 Provider-based Facility	49. Independent Clinic
	09. Prison/Correctional Facility	50. Federally Qualified Health Center
	11. Office	51. Inpatient Psychiatric Facility
	12. Home	52. Psychiatric Facility – Partial Hospitalization
	13. Assisted Living Facility	53. Community Mental Health Center
	14. Group Home	54. Intermediate Care Facility/Individuals with Intellectual Disabilities
	15. Mobile Unit	55. Residential Substance Abuse Treatment Facility
	16. Temporary Lodging	56. Psychiatric Residential Treatment Center
	17. Walk in Retail Health Clinic	57. Non-residential Substance Abuse Treatment Facility
	18. Place of Employment – Worksite	60. Mass Immunization Center
	19. Off Campus – Outpatient Hospital	61. Comprehensive Inpatient Rehabilitation Facility
	20. Urgent Care Facility	62. Comprehensive Outpatient Rehabilitation Facility
	21. Inpatient Hospital	65. End-Stage Renal Disease Treatment Facility
	22. On Campus – Outpatient Hospital	71. Public Health Clinic
	23. Emergency Room – Hospital	72. Rural Health Clinic
	24. Ambulatory Surgical Center	81. Independent Laboratory
	25. Birthing Center	99. Other Place of Service

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