

**** DO NOT USE THIS FORM FOR HEALTH CHOICE UTAH, MOLINA, HEALTHY U OR SELECTHEALTH REQUESTS ****

<p>*1. DATE OF REQUEST: _____</p> <p>*2. REQUESTED DATE(S) OF SERVICE: _____</p> <p>*3. RETROACTIVE REQUEST: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>*4. REQUEST CHANGE TO A CURRENT PA: <input type="checkbox"/> NO <input type="checkbox"/> YES PA # _____</p> <p>*5. NUMBER OF PAGES INCLUDED WITH REQUEST: _____</p> <p>*6. IS THIS REQUEST FOR AN INPATIENT CLIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p><u>FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO THE APPROPRIATE NUMBER ON THE ATTACHED INSTRUCTIONS PAGE</u></p> <p>OR MAIL TO: UTAH MEDICAID PRIOR AUTHORIZATION UNIT PO BOX 143111 SALT LAKE CITY, UT 84114-3111 FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS, PLEASE CALL: (801) 538-6155 OPTIONS 3, 3</p>			
*7. Patient Name: Last, First, M.I. _____	*8. Date of Birth _____	*9. Age _____	*10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	*11. Medicaid ID # _____
*12. Medical Supply, Therapy, Imaging or Procedure Requested <i>(List primary procedure first)</i>	*13. CPT, Medical Supply or Surgical Code	*14. Units/Visits Requested	15. Estimated Cost	
*1) _____	_____	_____	_____	
2) _____	_____	_____	_____	
3) _____	_____	_____	_____	
16. Will the service of an Anesthesiologist be used? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Will the service of an Assistant Surgeon be used? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>A. Is the above patient in an institution? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Does the above patient have an intellectual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Does the patient have a court appointed legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>C. Is the above patient in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Does the above patient have a mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>18. Hospital/Facility Name, Address and NPI # (Required if</p> <p>Name _____</p> <p>Address _____</p> <p>Phone (____) _____ Fax (____) _____</p> <p>NPI # _____</p>		<p>*19. Diagnosis Description & ICD-9-CM Code(s)</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>20. SUMMARY OF HISTORY: (Physical Examination, X-ray studies, prescriptions and other applicable documentation must be supplied in sufficient detail to justify the necessity for the procedure/supply that is being requested. Please see the appropriate Utah Medicaid manual for criteria of requested item/procedure)</p> <p>_____</p> <p>_____</p> <p>_____</p>				
<p>*21. Name, Address and NPI # of Requesting or Supplying Provider</p> <p>Name _____</p> <p>Address _____</p> <p>Phone (____) _____ Fax (____) _____</p> <p>Office Contact Name _____</p> <p>NPI # _____</p>		<p>*22. Name, Address and NPI # of Referring or Prescribing Provider</p> <p>Name _____</p> <p>Address _____</p> <p>Phone (____) _____ Fax (____) _____</p> <p>Office Contact Name _____</p> <p>NPI # _____</p>		
<p>THIS IS NOT A CERTIFICATE OF ELIGIBILITY NOR A GUARANTEE OF SERVICES REQUESTED. ELIGIBILITY MUST BE CONFIRMED FOR THE MONTH SERVICES ARE TO BE PROVIDED.</p> <p>*ASTERISK DENOTES A REQUIRED FIELD</p>				

USE THIS FORM FOR ADDITIONAL CODES CARRIED OVER FROM PAGE ONE OF THE PRIOR AUTHORIZATION REQUEST FORM

PATIENT NAME: _____ MEDICAID ID # _____

12. Medical Supply, Therapy, Imaging or Procedure Requested	13. CPT , Medical Supply or Surgical Code	14. Units Requested	15. Estimated Cost
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			

NOTE: For DME repair or replacement requests, provide the information below for the ORIGINAL item(s) that is being repaired or replaced

Description of DME	Medical Supply Code	Original Date of Delivery
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		

INSTRUCTIONS FOR REQUEST FOR PRIOR AUTHORIZATION FORM

ALL BOLDED INFORMATION BELOW MUST BE COMPLETED LEGIBLY AND CORRECT OR THE REQUEST WILL BE RETURNED WITHOUT BEING PROCESSED

1. **Date of request**
2. **Requested dates of service**
3. **Retroactive authorization** (check yes if request is for a date(s) of service prior to request date)
4. **Request change to a current prior authorization** (If yes, please provide the current PA #)
5. **Number of pages included with request**
6. **Is this request for an inpatient client?**
7. **Patient name**
8. **Date of birth**
9. **Age**
10. **Sex**
11. **Medicaid ID #** (Enter the entire 10 digit Medicaid Identification Number of recipient)
12. **Requested medical supply, therapy, imaging or procedure** (Up to 3 entries may be made on page 1, for additional entries please use "page 2 of Prior Authorization Request Form")
13. **Requested CPT, medical supply or surgical code** (Up to 3 entries may be made on page 1, for additional entries please use "page 2 of Prior Authorization Request Form")
14. **Amount of units requested** (Enter the number of times the procedure requested is to be performed or the total units required, please see the Medical Supplies Manual and List to determine units allowed per DME item)
15. **Estimated cost** (Enter estimated cost for supply/drug/therapy/procedure requested)
16. **Will Services of an anesthesiologist be used?**
17. **Will assistant surgeon be used?**
18. **Hospital/facility name & address:** include street address, city, state and zip code and facility NPI#. (Required if applicable)
19. **Diagnosis description & ICD-9-CM code**
20. **SUMMARY OF HISTORY** (Enter a narrative description of the patient's history)
21. **Name/address/contact information and NPI# of requesting or supplying provider:**
22. **Name/address/contact information of referring or prescribing provider**

PLEASE FAX PRIOR AUTHORIZATION REQUESTS AND ANY ATTACHMENTS TO THE NUMBERS BELOW:

- Outpatient Therapies (Speech, Occupational & Physical) & Diabetic Teaching.....**(801)536-0491**
- Sleep Studies, Hyperbaric Oxygen Therapy , CPAP/BiPAP & Supplies.....**(801)536-0167**
- Specialty Beds.....**(801)536-0166**
- Durable Medical Supplies & Inpatient Rehab.....**(801)536-0955**
- Surgeries.....**(801)536-0472**
- Wheelchairs**(801)536-0975**
- Dental ,Vision, Audiology, Genetic Testing & Transportation**(801)536-0958**
- Imaging.....**(801)536-0160**
- In Home Therapies (Occupational, Physical & Speech) & Home Health Services.....**(801)323-1562**
- Sterilizations & Transplants.....**(801)237-0789**
- Negative Pressure Wound Therapy**(801)536-0142**
- Private Duty Nursing**(801)536-0165**
- Emergency Only Program**(801)536-0475**
- Personal Care**(801)536-0157**
- All other requests.....**(801)536-0162**

IF FAX IS NOT AVAILABLE, MAIL THE ORIGINAL COMPLETED FORM AND ANY ATTACHMENTS TO:

MEDICAID PRIOR AUTHORIZATION
 BOX 143111
 SALT LAKE CITY UT 84114-3111
 Attention: Prior Authorization

Medicaid Information:

In the Salt Lake City area,**(801)538-6155**

Toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado**(800)662-9651**

From all other areas**(801)538-6155**