UTAH MEDICAID
REMITTANCE ADVICE FORM REQUEST

A Remittance Advice is not to be requested prior to *30 days* from the date of payment. Please Allow 7-10 business days for processing. If the remittance advice was originally sent electronically, contact your clearinghouse or vendor to request the remittance.

REQUESTOR INFORMATION

Name (PRINT) (*Required*) _____ Title (*Required*) _____

Billing Company Name (if applicable) _____ Phone # (*Required* (_____)_____

E-mail Address (*Required*) _____

Attestation: I declare under penalty of perjury that I am an authorized agent of the provider listed below, and therefore am entitled to receive the Remittance Advice or Health Care Claim Payment/Advice (835) transaction covered under HIPAA Privacy rules and regulations pertaining to release of Personal Health Information/Personally Identifiable Information (PHI/PII) information.

Signature (*Required*) _____ Date (*Required*) _____

PROVIDER INFORMATION

Provider/Facility Name (*Required*) _____ NPI/Contract Number-Atypical (*Required)* _____

Tax ID Number *(Required)* _____ Contact Name *(Required)* _____ Phone Number *(Required)* (_____)_____

Address (*Required*) _____ Suite _____

City (*Required)* _____ State *(Required)* _____ ZIP Code (*Required)* _____

One Provider Per Worksheet
** If the Remittance Advice requested is being sent via US Mail and is over 25 pages, a charge of $0.12 will be assessed for each additional page. Payment must be received before the remittance is mailed out.

Run Date (*Required)*	Warrant Number *(Required)*	Amount

For Official Use Only:

Action Taken: _____ _____
Name / Date

Return Document Request Form by mail or fax to:
Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0498