UTAH MEDICAID WARRANT REQUEST FORM

REQUESTOR INFORMATION

Name (PRINT) (*Required*) | Title (*Required*)

Billing Company Name (if applicable) | Phone # (*Required*) | E-mail Address (*Required*)

Address (*Required*) | Suite

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

SIGNATURE | 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*)

☐ **Warrant Tracer** (Paper Checks)

Warrant Date (Not Run Date) | Warrant # (*Required*) | Warrant Amount *Required)*

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Return Warrant Request Form by mail or fax to:

Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0476