Out of State Travel		
Cover Sheet		
(The Cover Sheet must be filled out completely and legibly or the request cannot be processed) Patient Name: DOB:		
Medicaid ID Number:	Medicaid Health Plan:	
Patient Diagnosis:	Weight:	
Does the Patient Need to be Accompanied During Travel? (Che		
If YES, Explain why Accompaniment is Required:		
Name of Person Accompanying Patient: (As it appears on License or Other Identification for Commercial Flights)		DOB:
Weight of Person Accompanying Patient:		
(This information is required if using Air Ambulance)		
Patient /Authorized Representative Name and Phone Number:		
Briefly Describe Current Medical Needs and Condition:		
Transportation Type Required: (Check all that Apply)		
Personal Vehicle Commercial Airline Air Ambulance: ( Fixed Wing Helicopter) Ground Ambulance		
Services Required During Transport: (Check all that Apply)		
□ Ventilator □ Oxygen □ Oximeter □ Cardiac Monitoring □ Respiratory Monitoring □ IV Requirements		
Catheter Nurse Medical Attendant Doctor Other	(Please Explain)	
Name of Medical Facility where Patient will Receive Services:		
Medical Facility Address:		
Medical Facility Contact Name:	Contact Phone:	
Contact Fax Number:	Contact E-mail Address:	
Treating Physician Name:	Phone:	
In Order to Process this Travel Request, the Following Items MUST be Provided Along with the Cover Sheet		
Letter of Medical Necessity and Supporting Medical Records		
<ul> <li>Letter of Acceptance from the Medical Facility that will be Accepting the Patient</li> </ul>		
Letter of Acceptance from Physician who will be treating the Patient (Letter must include physician		
contact information: phone, fax, pager, etc.)		
Treatment Proposal		
<ul> <li>Confirmation that the Medical Facility and Physician are Utah Medicaid Providers or Willing to Deserve Fund Had Describerts</li> </ul>		
Become Enrolled Providers O If the provider is not a current Utah Medicaid Provider, upon approval of the transportation request, payment		
rates for services will need to be negotiated with the Utah Medicaid Reimbursement Staff.		
Fax This Cover Sheet and the Required Accompanying Documentation to 801-536-0958:		
Attention: Out of State Travel Requests		
Inquiries About Out of State Travel Request may be Made by Calling:		
801-538-6155 or toll-free 800-662-9651, t	hen follow prompts: 3	3,3,1

For Medicaid Use Only:		
Out of State Travel Request Determination: 🗌 Approved 🗌 Denied		
Name of Reviewer:		
Signature of Reviewer:		
Fax results to: 801-536-0958, Address to: Attention Out of State Travel		
If the travel request is approved, fax the completed Cover Sheet to the Bureau of Eligibility		
Policy at: 801-538-6952.		
Prior to arranging Food and Lodging Reimbursement, the Bureau of Eligibility Policy will confirm that the following criteria have been met: (All Items must be Checked in Order to Be Eligible):		
<ul> <li>Patient is Eligible for Traditional Medicaid</li> <li>(Primary Care Network and Non-Traditional Medicaid recipients are not eligible for this benefit)</li> </ul>		
Patient is NOT receiving inpatient services		
$\Box$ The need for food and lodging must be for a time period greater than 2 consecutive nights		
The service being provided must be a Medicaid covered service		
The service must be obtained at the closest facility that can possibly provide the needed service		
Inquiries About Food and Lodging Reimbursement Requests may be Made by Calling: 801-538-6418		