Durable Medical Equipment & Medical Supplies
Prior Authorization Request Form

Instructions

- Complete this form fully and legibly. All fields with an asterisk (*) are required.
- For questions, call **(801) 538-6155** or toll free **(800) 662-9651** and select options **3, 3 then the appropriate number for the program**.
- For policy related to Medical Supplies and Durable Medical Equipment click here.
- Submit the completed form and all supporting documentation for requested service to one of the options below:

Fax: 801-536-0162
Email: fax_allotherauth_prior@utah.gov

Address: Utah Medicaid Prior Authorization
PO BOX 14311
Salt Lake City, UT 84114-3111

Member Information

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

Provider Information

9. Requesting provider:*	10. NPI:*
11. Address:*	
12. Contact person:*	13. Phone #:*
14. Contact information:* Fax #: Or Email address:	
15. Ordering provider:	16. NPI:
17. Ordering provider phone #:	

Request Information

18. Does code require a prior authorization?* ☐ No ☐ Yes https://health.utah.gov/stplan/lookup/CoverageLookup.php		
19. Date of submission:*	20. Requested date(s) of service: *	OR ☐ TBD
21. Total pages:	22. Request a change to a previous PA? * ☐ No ☐ Yes, Previous PA#:	
23. Is this a retroactive request? ☐ No ☐ Yes, list reason (required if "Yes"):		
24. If the request requires expedited review for medically necessary circumstances and delay of services may result in harm to the patient, provide additional justification **AND** call us at (801) 538-6155 or (800) 662-9651 (options 3, 3, 9).		
25. ICD 10 CM Code and/or Diagnosis Description:		

26. HCPCS code*	27. Modifier	28. Code Description*	29. Units*	30. Length of need*	31. Estimated cost
1.					
2.					
3.					
4.					
5.					
6.					

32. Additional Information

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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Use this page for additional codes that exceed lines on page one					
33. HCPCS code	**34. Modifier**	**35. Code Description**	**36. Units**	**37. Length of need**	**38. Estimated cost**
7.					
8.					
9.					
10.					
11.					
12.					
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24.					
25.					

NOTE: For DME repair or replacement requests, provide the information below for the item(s) that is being repaired or replaced. Enter the initial date of delivery or the most recent date of repair or replacement.

39. HCPCS Code	40. DME item description	41. Date of item delivery/repair	42. Quantity
1.			
2.			
3.			
4.			
5.			
6.			
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8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			