# Enteral Formula 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, 7**.
- For Policy related to Enteral Formula 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, attach substantiating justification **AND** call us at (801) 538-6155 or (800) 662-9651 (options 3, 3, 9). | |
| 25. Diagnosis description and/or ICD 10 CM code: | |

| 26. HCPCS code* | 27. Enteral product name* | 28. Kcalories/day | 29. Units requested* |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**Units = kcals per day ÷ 100 X number of days. If prescribed in flow rate, document calculation used in conversion to kcals per day:**

**Percentage of nutrition by tube** (request must include supporting documentation of percentage) _____%

## 30. 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.