

# Utah Medicaid Prior Authorization Request Form

Instructions				
<ul style="list-style-type: none"> <li>Complete this form fully and legibly. All fields with an asterisk (*) are required.</li> <li>Review the entire form to ensure all information for the requested service is completed. Incomplete forms will be returned. Some services require the completion of an additional form. Refer to the Medicaid website to view the required forms.</li> <li>Submit the completed form and all supporting documentation for the requested service to the appropriate fax number or email address below.</li> <li>For questions, call <b>(801) 538-6155</b> or toll free <b>(800) 662-9651</b> and select options <b>3, 3, then the appropriate number for the program.</b>  <b>Dental: FAX: 801-536-0958   EMAIL: fax_dental_prior@utah.gov</b>  <b>TAM Dental: FAX: 801-323-1560   EMAIL: fax_tamdentalservices_prior@utah.gov</b>  <b>Substance Use Disorder &amp; Inpatient Psychiatric Services: FAX: 801-323-1587   EMAIL: fax_mentalhealthservices_prior@utah.gov</b>  <b>All Other Authorization Requests: FAX: 801-536-0162   EMAIL: fax_allotherauth_prior@utah.gov</b> </li> </ul>				
Beneficiary Information				
1. Name (First, Middle Initial, Last): *			2. Beneficiary ID#: *	
3. Date of Birth: *		4. Age: *	5. Gender: * <input type="checkbox"/> Female <input type="checkbox"/> Male	
6. Is the member in a skilled nursing facility? <input type="checkbox"/> No <input type="checkbox"/> Yes, Facility Name:			Facility Phone #:	
7. Has eligibility been verified? <input type="checkbox"/> No <input type="checkbox"/> Yes				
8. Is the member enrolled in a managed care entity (MCE)? <input type="checkbox"/> No <input type="checkbox"/> Yes, contact member's MCE				
9. Is the request for a carve out service? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Provider Information				
10. Requesting Provider: *			11. NPI: *	
12. Requesting Provider Address: *				
13. Rendering/Service Provider: *			14. NPI: *	
15. Rendering/Service Provider Address: *				
16. Contact Person: *			17. Phone #: *	
18. Contact information: * Fax #:		Or	Email address:	
Request Information				
19. Date of submission: *		20. Requested date(s) of service: *		OR <input type="checkbox"/> TBD
21. Total pages:		22. Request a change to a previous PA? * <input type="checkbox"/> No <input type="checkbox"/> Yes, Previous PA#:		
23. Is this a retroactive request? * <input type="checkbox"/> No <input type="checkbox"/> Yes, list reason (Required if "Yes"):				
24. Facility Code Qualifier (see page three): *			25. Facility Type Code (see page three): *	
26. ICD 10 CM Diagnosis Code: *				
27. CPT or HCPCS code*	28. Code Description*	29. Modifier	30. Units or Visits*	31. Dental Quadrant(s)
1.				
2.				
3.				
4.				
5.				
32. Delivery Pattern (required for Home Health, Hospice, PDN, Speech Therapy, Physical Therapy, and Occupational Therapy)				
Service Delivery Pattern (e.g., 2 visits per every 3 days for 21 days):				
Calendar Pattern (e.g., 1 <sup>st</sup> week of the month, M-F):				
Time Pattern (e.g., 1 <sup>st</sup> shift, any shift):				
33. Enteral Formula				
Kcalories per day:			Percentage of nutrition by tube:	
<i>Units = kcals per day ÷ 100 X number of days. If prescribed in flow rate, document calculation used in conversion to kcals per day.</i>				
34. Physical Therapy and Occupational Therapy				
<input type="checkbox"/> Physical Therapy (97010-97136, 97110-97124, 97140-97533)		Number of Visits:	Have PT Limits been met? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Occupational Therapy (97010-97136, 97110-97124, 97140-97533)		Number of Visits:	Have OT Limits been met? <input type="checkbox"/> Yes <input type="checkbox"/> No	
35. Urine Drug Testing				
<input type="checkbox"/> Presumptive test (limited to 8/30-day period)			<input type="checkbox"/> 80305 <input type="checkbox"/> 80306 <input type="checkbox"/> 80307	
<input type="checkbox"/> Definitive test (limited to 1/30-day period)			<input type="checkbox"/> G0480 <input type="checkbox"/> G0481 <input type="checkbox"/> G0482 <input type="checkbox"/> G0483	
36. Home Health, PDN, and Hospice (required for these services)				
Prognosis: <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very Good <input type="checkbox"/> Excellent <input type="checkbox"/> Less than 6 months to live <input type="checkbox"/> Terminal				
Certification Period:			Physician Order Date:	

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37. Additional Information				

38. CPT or HCPCS code*	39. Code Description*	40. Modifier	41. Units or Visits*	42. Dental Quadrant(s)
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Facility Code Qualifier	Facility Type Code	
A. Uniform Billing Claim Form Bill Type	11. Hospital Inpatient (includes Part A)	71. Clinic – Rural Health
	12. Hospital Inpatient (Part B only)	72. Clinic – Hospital Based or Independent Renal Dialysis Center
	13. Hospital Outpatient	73. Clinic - Freestanding
	14. Hospital – Lab Services to Non-Patients	74. Clinic – Outpatient Rehabilitation Facility
	18. Hospital – Swing Beds	75. Clinic – Comprehensive Outpatient Rehabilitation Facility
	21. Skilled Nursing – Inpatient (including Part A)	76. Clinic – Community Mental Health Center
	22. Skilled Nursing – Inpatient (Part B only)	77. Clinic – FQHC
	23. Skilled Nursing – Outpatient	78. Licensed Freestanding Emergency Medical Facility
	28. Skilled Nursing – Swing Beds	79. Clinic – Other
	32. Home Health – Inpatient (Part B only)	81. Hospice (non-hospital based)
	33. Home Health (under PPS)	82. Hospice (hospital based)
	34. Home Health (not under PPS)	83. Ambulatory Surgery Center
	41. Religious Non-Medical Health Care Institutions – Hospital Inpatient	84. Freestanding Birthing Center
	43. Religious Non-Medical Health Care – Outpatient	85. Critical Access Hospital
	65. Intermediate Care – Level I	86. Residential Facility
	66. Intermediate Care – Level II	89. Specialty Facility - Other
B. Place of Service Codes for Professional or Dental Services	01. Pharmacy	26. Military Treatment Facility
	02. Telehealth	31. Skilled Nursing Facility
	03. School	32. Nursing Facility
	04. Homeless Shelter	33. Custodial Care Facility
	05. Indian Health Services Free-standing Facility	34. Hospice
	06. Indian Health Services Provider-based Facility	41. Ambulance – Land
	07. Tribal 638 Free-standing Facility	42. Ambulance – Air or Water
	08. Tribal 638 Provider-based Facility	49. Independent Clinic
	09. Prison/Correctional Facility	50. Federally Qualified Health Center
	11. Office	51. Inpatient Psychiatric Facility
	12. Home	52. Psychiatric Facility – Partial Hospitalization
	13. Assisted Living Facility	53. Community Mental Health Center
	14. Group Home	54. Intermediate Care Facility/Individuals with Intellectual Disabilities
	15. Mobile Unit	55. Residential Substance Abuse Treatment Facility
	16. Temporary Lodging	56. Psychiatric Residential Treatment Center
	17. Walk in Retail Health Clinic	57. Non-residential Substance Abuse Treatment Facility
	18. Place of Employment – Worksite	60. Mass Immunization Center
	19. Off Campus – Outpatient Hospital	61. Comprehensive Inpatient Rehabilitation Facility
	20. Urgent Care Facility	62. Comprehensive Outpatient Rehabilitation Facility
	21. Inpatient Hospital	65. End-Stage Renal Disease Treatment Facility
	22. On Campus – Outpatient Hospital	71. Public Health Clinic
	23. Emergency Room – Hospital	72. Rural Health Clinic
	24. Ambulatory Surgical Center	81. Independent Laboratory
	25. Birthing Center	99. Other Place of Service