UTAH DEPARTMENT OF HEALTH MEDICAID

General Prior Authorization Request Form

Instructions

- Complete this form fully and legibly. All fields with an asterisk (*) are required.
- Submit the completed form and all supporting documentation for requested service to the appropriate fax number below. Requests sent to an incorrect fax number will not be processed. Always verify the fax number prior to submission of protected health information.
- For questions, call **(801) 538-6155** or toll free **(800) 662-9651** and select options **3, 3, then the appropriate number for the program**.
- Use this form only when there is not a program specific form for the service being requested.

Program	FAX	Email	Address
Dental	801-536-0958	fax_dental_prior@utah.gov	Utah Medicaid Prior Authorization Unit
TAM Dental	801-323-1560	fax_tamdentalservices_prior@utah.gov	PO BOX 14311
Other	801-536-0162	fax_allotherauth_prior@utah.gov	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 request for a carve out service? ☐ No ☐ Yes

9. Is the member in a skilled nursing facility? * ☐ No ☐ Yes, Facility Name: Phone:

10. Does the member have a court appointed legal guardian? ☐ No ☐ Yes (Field required for primary sterilization procedures only)

Provider Information

11. Requesting Provider:* 12. NPI:*

13. Address:*

14. Contact person:* 15. Phone #:*

16. Contact information:* Fax #: Or Email address:

17. Facility/Clinic Name: 18. NPI:

19. Facility/Clinic Address:

Request Information

20. Does code require a prior authorization?* ☐ No ☐ Yes https://health.utah.gov/stplan/lookup/CoverageLookup.php

21. Date of submission:* 22. Requested date(s) of service:* _______________ - _______________ OR ☐ TBD

23. Total pages: 24. Request a change to a previous PA?* ☐ No ☐ Yes, Previous PA#:

25. Is this a retroactive request? * ☐ No ☐ Yes, list reason (Required if "Yes"):

26. Will the service of an anesthesiologist be used? ☐ No ☐ Yes

27. 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).

28. ICD 10 CM Code and/or Diagnosis Description:

29. CPT or HCPCS code*	30. Code Description*	31. Modifier	32. Units or Visits*
1.			
2.			
3.			
4.			

33. 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.

Last Updated: 1/4/21

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Use this page for additional codes that exceed lines on page one			
34. CPT or HCPCS code	**35. Code Description**	**36. Modifier**	**37. Units or Visits**
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