UTAH DEPARTMENT OF HEALTH MEDICAID

Home Health & Personal Care
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, 8**.
- For policy related services click here for home health and here personal care services.
- Submit the completed form and all supporting documentation for requested service to one of the options listed 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 for dates of MCE eligibility		

Provider Information

8. Requesting Provider:*	9. NPI:*
10. Address:*	
11. Contact person:*	12. Phone #:*
13. Contact information:* Fax #: Or Email address:	
14. Provider Type: ☐ 54 Personal care agency ☐ 58 Medicare certified home health agency	

Request Information

15. Does code require a prior authorization?* ☐ No ☐ Yes https://health.utah.gov/stplan/lookup/CoverageLookup.php	
16. Date of submission:*	17. Date(s) of resubmission if applicable:
18. Certification period dates:* _____ - _____ (from 485 POC)	19. Total pages:
20. Request a change to a previous PA? * ☐ No ☐ Yes, Previous PA#: (complete field 27)	
21. Is this a retroactive request? ☐ No ☐ Yes, list reason (Required if "Yes"):	
22. 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).	
23. Diagnosis description:*	24. Date of last face-to-face:*

25. HCPCS code*	26. Description* (e.g. nurse, PT, HHA)	27. Check if Modification (Explain in field 30)	28. Date(s) of service*	29. Units/ Visits*	30. Frequency (e.g. 2w1, 1w7)
1.		☐			
2.		☐			
3.		☐			
4.		☐			
5.		☐			
6.		☐			

31. Additional Information: