Hospice Services 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 to Hospice 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 the member's MCE if not in a facility		
8. County of residence:*	9. Initial hospice admit date:	

Provider Information

10. Requesting Provider:*	11. NPI:*
12. Address:*	
13. Contact person:*	14. Phone #:*
15. Contact information:* Fax #: Or Email address:	

If patient is in a skilled nursing facility, ICF/ID, or freestanding inpatient hospice and hospice agency will bill and of T2044, T2045, or T2046

16. Name:	17. NPI:
18. Address:	19. Facility admission date:

Request Information

20. Date of submission:*	21. Total pages:	22. Face-to-face date:
23. Certification dates:* _____ - _____	24. Election/Benefit Period (e.g. 1,5,7):*	
25. Request a change to, or notification for, a previous PA? * ☐ No ☐ Yes, Previous PA#:		
26. Is this a retroactive request? ☐ No ☐ Yes, list reason (Required if "Yes"):		
27. Primary terminal diagnosis:*		

28. **Service(s) Requested***	29. **Start date – End date***	30. **Units/#Days/#hours**
☐ T2042 Routine Home Care		
☐ T2043 Continuous Homecare		
☐ T2044 Inpatient Respite		
☐ T2045 General Inpatient (GIP)		

Discharge Notification

31. Date:	32. Status change: ☐ Discharge for cause ☐ No longer qualifies ☐ Not eligible ☐ Death ☐ Patient moved ☐ Voluntary revocation ☐ Transfer, transfer to:

Re-election Information

33. Date of re-election:	34. Date of last Discharge/revocation:
35. Was member in the 1st election period at time of last discharge? ☐ No ☐ Unknown ☐ Yes, days used:	

36. 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.

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.