UTAH DEPARTMENT OF HEALTH MEDICAID

Hospice Care
Prior Authorization Request Form

* All fields with an asterisk (*) are required fields and must be completed legibly or the request will be returned without being processed

*1. Date of Request: _____

*2. Certification Dates: _____ - _____

*3. Election Period: _____

*4. Is this a change to a previous PA: ☐ No ☐ Yes Previous PA#_____

*5. Is this a retroactive request: ☐ No ☐ Yes Reason for retroactive request: _____

_____

FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO:
(801) 323-1562

OR MAIL TO:
UTAH MEDICAID PRIOR AUTHORIZATION UNIT
PO BOX 143111
SALT LAKE CITY, UT 84114-3111

Member Information

*6. Member Name:	*7. Member ID#:	*8. Date of Birth:	*9. Age:
*10. Gender: ◯ Male ◯ Female	*11. County of Residence:	*12. Initial Hospice Admit Date:	
*13. Date of Physician Certification:	*14. Certifying Physician's Name:		
*15.Primary Terminal ICD-10 Diagnosis and Condition Description:			
16. Secondary Terminal ICD-10 Diagnosis and Condition Description:			

*17. Payer at time of Election:
☐ Medicare
☐ Medicaid
☐ ACO Health Plan
☐ Other/Private

*18.Was the Member Medicaid Eligible at the Time of Initial Admission?
☐ Yes (If "yes" submit this form, copies of the signed election statement, and physician's certification statement within 10 calendar days of admission).
☐ No (if "no," complete this form and attach initial plan of care, physician certification statement, and signed Election statement. Do NOT submit documents until after Medicaid eligibility is established).

Hospice Provider Information

*19. Provider Name:	*20. Provider NPI #:
*21. Provider Address: _____ _____	*22. Provider Phone Number: (___)_____Ext._____ Office Contact Name: *23. Provider Fax Number: ( )

Facility Information (If patient is residing in a skilled nursing facility, ICF/IF, or freestanding inpatient hospice)

24. Facility Name:	25. Facility NPI #:
26. Facility Address: _____ _____	27. Facility Admission Date: 28. Requested Start Date:

29. Hospice Benefit(s) Requested

	Requested Start Date	Requested End Date	
☐ Routine Home Care (T2042)			Who is funding T2042 ☐ Medicare ☐ Medicaid ☐ Other/Private
☐ General Inpatient (T2045)			Facility/Hospital Name:
☐ Inpatient Respite (T2044)			Facility Name:
☐ Continuous Home care (T2043)			# of hours requested:

30. Discharge Notification

Type of discharge: ☐ Voluntary revocation ☐ No longer qualifies ☐ Discharge for cause ☐ Transfer ☐ Death: ☐ Patient moved ☐ Not eligible

Discharge Date:	Transfer Date:	Death Date:

31. Re-Election Information

Date of re-election:	Date of last discharge/revocation:

Was the client in his/her initial election period at the time of the last discharge? ☐ No ☐ Yes ☐ Unknown

32. Comments:

_____
_____
_____
_____

FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS PLEASE CALL: (801) 538-6155 OPTIONS 3, 3, 8

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INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

1. **Date of request** – Enter the date you are submitting the request
2. **Certification Dates -** Enter the appropriate certification period date range
3. **Election Period** - Enter the current election period for which you are requesting (e.g. 1, 2, 3, etc)
4. **Is this a change to a Previous PA -** (If yes, please provide the current PA #)
5. **Is this a Retroactive Request? -** (If yes, provide the reason for retroactive request)
6. **Member Name –** Enter the first and last name of the member
7. **Member ID#** - Enter the entire 10 digit Medicaid Identification Number of recipient
8. **Date of Birth** – Enter member date of birth
9. **Age** – Enter member age
10. **Gender** - Select member gender
11. **County of Residence** – Enter member county of residence
12. **Initial hospice Admit Date** – Enter date the member was initially admitted to hospice
13. **Date of Physician Certification** – Enter date of the physician certification of terminal illness
14. **Certifying Physician's Name** – Enter the physician name that is signing the certification of terminal illness
15. **Primary Terminal ICD-10 Diagnosis and Condition Description** – Enter the primary terminal diagnosis and condition description
16. **Secondary Terminal ICD-10 Diagnosis and Condition Description** – Enter the secondary terminal diagnosis and description if applicable
17. **Payer at time of Election** – Check applicable payers at the time of election
18. **Is the Member Eligible at the Time of Initial Admission**
19. **Provider Name –** Enter hospice provider name
20. **Provider NPI# -** Enter hospice provider NPI#
21. **Provider Address –** Enter hospice provider address
22. **Provider Phone Number –** Enter phone number you would like communication about this request referred (include office contact name)
23. **Provider Fax Number** – Enter appropriate fax number for which correspondence should be sent
24. **Facility Name –** Enter name of skilled nursing facility, ICF/ID, or freestanding inpatient hospice if the patient resides in a facility
25. **Facility NPI # -** Enter NPI # of facility where the member resides
26. **Facility Address –** Enter facility address where the member resides
27. **Facility Admission Date** – Enter date member was admitted to facility
28. **Requested Start Date –** Enter date Medicaid reimbursement is requested to start
29. **Hospice Benefit(s) requested** – Check the benefit(s) requested, complete the requested start date and requested end date, and complete remaining applicable documentation
30. **Discharge Notification –** Complete this section if the member is being discharged from the hospice agency.
31. **Re-election Information –** Complete this section in addition to applicable above information if member has re-elected the hospice benefit
32. **Comments –** Use this section to document any additional information or clarification for the request

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