Mental Health Residential Treatment Services- Individuals Age 21-64
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, 6**.
- For policy related to Mental Health Residential Treatment Services click here.
- 7 days may be requested at a time for a maximum of 60 days per admission.
- Submit the completed form and all supporting documentation for requested service to one of the options below:

Fax: 801-323-1587
Email: fax_mentalhealthservices_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 PMHP or UMIC plan		

Provider Information

8. Requesting Provider:*	9. NPI:*
10. Address:*	
11. Contact person:*	12. Phone #:*
13. Contact information:* Fax #: Or Email address:	

Request Information

Previous Authorization Information (required if previous authorization is from fee-for-service Medicaid)

14. Original date of admission to treatment center:	
15. Previous PA#:	16. Previous PA date range:

Current Authorization Information

17. Date of submission:*	18. Requested date(s) of service: * _____ - _____	
19. Total pages:	20. Request a change to a previous PA?* ☐ No ☐ Yes, Previous PA#:	(explain in field 25)
21. Is this a retroactive request?* ☐ No ☐ Yes, list reason in field 25 (Required if "Yes")		
22. Request type: ☐ Non-clinical ☐ Clinical		

23. Service	24. Total days requested* (7 day Limit Per Request)
H0017 – (17 or more beds) Behavioral health; residential, without room and board, per diem	

25. Additional Information

Additional information required for clinical authorization

Fee- for- Service Medicaid utilizes InterQual Residential Criteria to review medical necessity

a) **Documentation:** Must clearly articulate how the beneficiary meets medical necessity for continuation of service
b) **Estimated length of stay**
c) **Discharge plan and anticipated discharge date**

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.