



Physical Therapy and Occupational Therapy Prior Authorization Request Form

<p>*1. Date of submission: _____</p> <p>*2. Is this a retroactive request? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, list reason in the "additional information" section below)</p> <p>*3. Is this request a change to a previous PA? <input type="checkbox"/> No <input type="checkbox"/> Yes Previous PA# _____</p> <p>*4. Type of Therapy requested? <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Both</p> <p>*5. Requested dates of service: _____ - _____</p> <p>*6. Requested number of visits: _____</p>	Member Information		
	<p>*10. Member Name:</p>		
	<p>*11. Member ID#:</p>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">*12. Date of Birth:</td> <td style="width: 50%;">*13. Age:</td> </tr> </table>	*12. Date of Birth:	*13. Age:
*12. Date of Birth:	*13. Age:		
	<p>14. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/></p>		

Note: For the purposes of determining when limitations have been met for occupational and physical therapy, Utah Medicaid considers each date of service to be one (1) visit, regardless of how many modalities are provided on that date of service.

<p>*7. Medicaid Program Coverage (must choose one) https://medicaid.utah.gov/eligibility</p> <p><input type="checkbox"/> Traditional <i>(Prior authorization is not required for the first twenty (20) physical therapy or the first twenty (20) occupational therapy services (The evaluation for either PT or OT is not counted as one of the 20 visits). The first twenty (20) visits per calendar year, per member, per type of therapy are reimbursable without prior authorization. Prior authorization is only required for more than 20 visits per calendar year)</i></p> <p><input type="checkbox"/> Non-Traditional <i>(Non-traditional Medicaid allows 16 combined therapy visits yearly in any arrangement, e.g., all PT, all OT, or mixed. The evaluation for either PT or OT is not counted as one of the 16 visits. The first sixteen (16) visits per calendar year, per member, are reimbursable without prior authorization. Prior authorization is only required for more than 16 sessions per calendar year)</i></p> <p>*8. Have physical therapy limitations been met? (see limits above) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>*9. Have occupational therapy limitations been met? (see limits above) <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><u>SUBMIT THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO:</u></p> <p>FAX: (801) 536-0491</p> <p>OR</p> <p>MAIL TO:</p> <p>UTAH MEDICAID PRIOR AUTHORIZATION UNIT PO BOX 143111 SALT LAKE CITY, UT 84114-3111</p> <p>FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS PLEASE CALL: (801) 538-6155 OPTIONS 3, 3, 5</p>
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Provider Information		
<p>*15. Provider Name</p>	<p>*16. Provider NPI #</p>	
<p>*17. Provider Address</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>*18. Provider Phone Number</p> <p>() _____ Ext. _____</p>	<p>*20. Provider Fax Number</p> <p>() _____</p>
	<p>*19. Office Contact Name</p> <p>_____</p>	

Additional Information

PRIOR AUTHORIZATION DOES NOT GUARANTEE REIMBURSEMENT. ALL OTHER MEDICAID REQUIREMENTS MUST BE MET IN ORDER FOR A PROVIDER TO RECEIVE REIMBURSEMENT, INCLUDING VERIFYING CODE COVERAGE FOR EACH PROVIDER TYPE. UTAH MEDICAID PROVIDERS ARE EXPECTED TO CHECK ELIGIBILITY AT EACH VISIT, INCLUDING HEALTH PLAN PARTICIPATION AND RESTRICTED MEMBER STATUS. ALL CLAIMS ARE SUBJECT TO CORRECT CODING AND ASSOCIATED MUE VALUES REGARDLESS OF SERVICES THAT HAVE BEEN PRIOR AUTHORIZED.



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INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

ALL BOLDDED INFORMATION BELOW MUST BE COMPLETED LEGIBLY AND CORRECT OR THE REQUEST WILL BE RETURNED WITHOUT BEING PROCESSED

1. **Date of submission**
2. **Is this a retroactive request** (If yes, list reason in the "additional information" section)
3. **Is this request a change to a previous prior authorization?** (If yes, please provide the PA #)
4. **Type of therapy required?** (choose the type of therapy you are requesting)
5. **Requested dates of service** (enter the first date that services are being requested and the last date that services are being requested)
6. **Requested number of visits** (enter the number of individual days the patient will come in for services between the "requested dates of service")
7. **Note:** *For the purposes of determining when limitations have been met for occupational and physical therapy, Utah Medicaid considers each date of service to be one (1) visit, regardless of how many modalities are provided on that date of service.*
8. **Medicaid program coverage**
 - Traditional**

*(Prior authorization is not required for the first twenty (20) physical therapy or the first twenty (20) occupational therapy services (The evaluation for either PT or OT is not counted as one of the 20 visits). The first twenty (20) visits per calendar year, per member, per type of therapy are reimbursable without prior authorization. **Prior authorization is only required for more than 20 visits per calendar year**)*
 - Non-Traditional**

*(Non-traditional Medicaid allows 16 combined therapy visits yearly in any arrangement, e.g., all PT, all OT, or mixed. The evaluation for either PT or OT is not counted as one of the 16 visits. The first sixteen (16) visits per calendar year, per member, are reimbursable without prior authorization. **Prior authorization is only required for more than 16 sessions per calendar year**)*
9. **Have physical therapy limitations been met?** (Only submit authorization requests for services that will exceed the allowable amount without PA)
10. **Have occupational therapy limitations been met** (Only submit authorization requests for services that will exceed the allowable amount without PA)
11. **Member name**
12. **Member ID#** (Enter the entire 10 digit Medicaid Identification Number of recipient)
13. **Date of birth**
14. **Age** (on beginning date of service)
15. **Gender**
16. **Provider name**
17. **Provider NPI #**
18. **Provider address**
19. **Provider phone number** (Please include a direct phone number)
20. **Office contact name**
21. **Provider fax number**

Please refer to the [Utah Medicaid Provider Manual for Physical Therapy and Occupational Therapy Services](#), for more detailed information.