UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

PERSONAL CARE AND CAPITATED PROGRAM PRIOR AUTHORIZATION REQUEST FORM

DO NOT USE THIS FORM FOR PRIOR AUTHORIZATION REQUESTS OTHER THAN PERSONAL CARE AND CAPITATED PROGRAMS

DATE OF REQUEST: _____	**FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO :** **(801) 536-0157**	**STATE USE ONLY**	
		EFFECTIVE DATE	
		TERMINATION DATE	

1. Patient Name: Last, First, M.I.	**2. Date of Birth**	**3. Age**	**4. Sex** □ Male □ Female	**5. Medicaid ID #**

6. Medical Supply, Therapy, Imaging or Procedure Requested ***(List primary procedure first)***	**7. CPT , Medical Supply or Surgical Code**	**8. Units Requested**	**STATE USE ONLY**		
			Estimated Cost	**Units**	**YES/NO**
1)					
2)					
3)					

14. SUMMARY OF HISTORY: (Physical Examination, X-ray studies, prescriptions and other applicable documentation must be supplied in sufficient detail to justify the necessity for the procedure/supply that is being requested. Please see the appropriate Utah Medicaid manual for criteria of requested item/procedure)

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15. Name, Address and NPI # of Requesting or Supplying Provider

Name_____

Address _____

_____

Phone #_____Fax #_____

Office Contact Name_____

NPI # _____

16. Name, Address and NPI # of Referring or Prescribing Provider

Name_____

Address _____

_____

Phone #_____Fax #_____

Office Contact Name_____

NPI # _____

NOTE: THIS IS NOT A CERTIFICATE OF ELIGIBILITY NOR A GUARANTEE OF PAYMENT AMOUNT REQUESTED. ELIGIBILITY MUST BE CONFIRMED BY REVIEWING AN ELIGIBLITY CARD CURRENT FOR THE MONTH SERVICES ARE TO BE PERFORMED.

STATE USE ONLY

_____ _____ _____

REVIEWER ID **SIGNATURE OF REVIEWING AUTHORITY** **APPROVAL DATE**