

**\*DO NOT USE THIS FORM FOR HEALTH CHOICE UTAH, MOLINA, HEALTHY U OR SELECTHEALTH REQUESTS\***

<p>1. DATE OF REQUEST: _____</p> <p>2. REQUESTED DATE(S) OF SERVICE: _____ - _____</p> <p>3. RETROACTIVE REQUEST: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. REQUEST CHANGE TO A CURRENT PA: <input type="checkbox"/> NO <input type="checkbox"/> YES PA # _____</p> <p>5. NUMBER OF PAGES INCLUDED WITH REQUEST: _____</p> <p>6. IS THIS REQUEST FOR AN INPATIENT CLIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p><b><u>FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO THE APPROPRIATE NUMBER ON THE ATTACHED INSTRUCTIONS PAGE</u></b></p> <p><b>OR MAIL TO:</b></p> <p><b>UTAH MEDICAID PRIOR AUTHORIZATION UNIT</b>  <b>PO BOX 143111</b>  <b>SALT LAKE CITY, UT 84114-3111</b></p> <p>FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS , PLEASE CALL:  <b>(801) 538-6155 OPTIONS 3, 3</b></p>				
7. Patient Name: Last, First, M.I. _____		8. Date of Birth _____	9. Age _____	10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Medicaid ID # _____	
12. Medical Supply, Therapy, Imaging or Procedure Requested <i>(List primary procedure first)</i>		13. CPT , Medical Supply or Surgical Code	14. Units/Visits Requested	15. Estimated Cost		
1)						
2)						
3)						
16. Will the service of an Anesthesiologist be used? <input type="checkbox"/> Yes <input type="checkbox"/> No			17. Will the service of an Assistant Surgeon be used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
A. Is the above patient in an institution? <input type="checkbox"/> Yes <input type="checkbox"/> No		C. Is the above patient in a nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No		B. Does the above patient have an intellectual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
E. Does the patient have a court appointed legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		D. Does the above patient have a mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No				
18. Hospital/Facility Name, Address and NPI # Name _____ Address _____ Phone (____) _____ Fax (____) _____ NPI # _____			19. Diagnosis Description & ICD-9-CM Code(s) _____ _____ _____			
20. 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) _____ _____ _____						
21. Name, Address and NPI # of Requesting or Supplying Provider Name _____ Address _____ Phone (____) _____ Fax (____) _____ Office Contact Name _____ NPI # _____			22. 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 ELIGIBILITY CARD CURRENT FOR THE MONTH SERVICES ARE TO BE PERFORMED.						

**\*\*\*USE THIS FORM FOR ADDITIONAL CODES CARRIED OVER FROM PAGE ONE OF THE PRIOR AUTHORIZATION REQUEST FORM\*\*\***

PATIENT NAME: \_\_\_\_\_ MEDICAID ID # \_\_\_\_\_

12. Medical Supply, Therapy, Imaging or Procedure Requested <i>(Do not include codes from page 1)</i>	13. CPT , Medical Supply or Surgical Code	14. Units Requested	15. Estimated Cost
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			

**INSTRUCTIONS FOR REQUEST FOR PRIOR AUTHORIZATION FORM**

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

1. **Date of request**
2. **Requested dates of service**
3. **Retroactive authorization** (check yes if request is for a date(s) of service prior to request date)
4. **Request change to a current prior authorization** (If yes, please provide the current PA #)
5. **Number of pages included with request**
6. **Is this request for an inpatient client?**
7. **Patient name**
8. **Date of birth**
9. **Age**
10. **Sex**
11. **Medicaid ID #** (Enter the entire 10 digit Medicaid Identification Number of recipient)
12. **Requested medical supply, therapy, imaging or procedure** (Up to 3 entries may be made on page 1, for additional entries please use "page 2 of Prior Authorization Request Form")
13. **Requested CPT, medical supply or surgical code** (Up to 3 entries may be made on page 1, for additional entries please use "page 2 of Prior Authorization Request Form")
14. **Amount of units requested** (Enter the number of times the procedure requested is to be performed or the total units required, please see the Medical Supplies Manual and List to determine units allowed per DME item)
15. **Estimated cost** (Enter estimated cost for supply/drug/therapy/procedure requested)
16. **Will Services of an anesthesiologist be used?**
17. **Will assistant surgeon be used?**
18. **Hospital/facility name & address: include street address, city, state and zip code and facility NPI#.**
19. **Diagnosis description & ICD-9-CM code**
20. **SUMMARY OF HISTORY** (Enter a narrative description of the patient's history)
21. **Name/address/contact information and NPI# of requesting or supplying provider:**
22. **Name/address/contact information of referring or prescribing provider**

PLEASE FAX PRIOR AUTHORIZATION REQUESTS AND ANY ATTACHMENTS TO THE NUMBERS BELOW:

- Outpatient Therapies (Speech, Occupational & Physical) & Diabetic Teaching.....(801)536-0491
- Sleep Studies, Hyperbaric Oxygen Therapy , CPAP/BiPAP & Supplies.....(801)536-0167
- Specialty Beds.....(801)536-0166
- Durable Medical Supplies & Inpatient Rehab.....(801)536-0955
- Surgeries.....(801)536-0472
- Wheelchairs .....(801)536-0975
- Dental ,Vision, Audiology, Genetic Testing & Transportation .....(801)536-0958
- Imaging.....(801)536-0160
- In Home Therapies (Occupational, Physical & Speech) & Home Health Services.....(801)323-1562
- Sterilizations & Transplants.....(801)237-0789
- Negative Pressure Wound Therapy .....(801)536-0142
- Private Duty Nursing .....(801)536-0165
- Emergency Only Program .....(801)536-0475
- All other requests.....(801)536-0162

IF FAX IS NOT AVAILABLE, MAIL THE ORIGINAL COMPLETED FORM AND ANY ATTACHMENTS TO:

MEDICAID PRIOR AUTHORIZATION  
 BOX 14311  
 SALT LAKE CITY UT 84114-3111  
 Attention: Prior Authorization

Medicaid Information:  
 In the Salt Lake City area, . . . . .(801)538-6155  
 Toll-free in Utah, Arizona, New Mexico, Nevada Idaho, Wyoming and Colorado . . . . .(800)662-9651  
 From all other areas . . . . .(801)538-6155