Utah Medicaid Provider Manual
Division of Medicaid and Health Financing

Request for Prior Authorization
Updated July 2017
FORM NUMBER
24 06 37

*VERIFY APPROPRIATE FAX NUMBER ON PAGE 3 BEFORE SENDING PROTECTED HEALTH INFORMATION *

*1. MEDICAID MEMBER ID:_____

*2. MEDICAID MEMBER NAME:
_____

*3. DATE OF BIRTH: _____

*4. AGE: _____ 5. GENDER ☐Male ☐ Female

*6. HAS ELIGIBILITY BEEN VERIFIED? ☐Yes ☐No
https://medicaid.utah.gov/eligibility

*7. IS THE MEMBER ENROLLED IN A MANAGED CARE ORGANIZATION?
☐Yes ☐No (If yes, contact the member's MCO for prior authorization)

*8. DOES THE SERVICE CODE BEING REQUESTED REQUIRE PRIOR AUTHORIZATION? ☐Yes ☐No
http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

*9. DATE OF REQUEST:_____

*10.REQUESTED DATE(S) OF SERVICE:
_____-_____

*11. RETROACTIVE REQUEST:☐YES☐NO
(If yes, reason for retroactive request is required)
_____
_____

*12. CHANGE TO AN EXISTING PA:☐NO☐YES
If yes, PA#: _____

*13. NUMBER OF PAGES INCLUDED WITH REQUEST: _____

*14. IS THIS REQUEST FOR HOME HEALTH SERVICES? ☐YES☐NO
(If yes, provider type is required)
PT 54- Personal Care Agency ○ PT 58-Medicare Certified Home Health Agency ○

*15. MEDICAL SUPPLY, THERAPY, IMAGING OR PROCEDURE DESCRIPTION	*16. CPT/HCPCS	17. MODIFIER	*18. UNITS/VISITS	19. ESTIMATED COST
1)				
2)				
3)				

*20. DIAGNOSIS DESCRIPTION & ICD-10-CM CODE(S): _____
_____

21. WILL THE SERVICE OF AN ANESTHESIOLOGIST BE USED?
☐Yes ☐No

*22. IS THIS A REQUEST FOR A MEMBER IN A SKILLED NURSING FACILITY?
☐Yes ☐No
Facility Name: _____Phone: _____

23. DOES THE PATIENT HAVE A COURT APPOINTED LEGAL GUARDIAN?
(Required for primary sterilization procedures, e.g. tubal ligation, vasectomy)
☐Yes☐No

24. 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):
NOTE: Supporting documentation must be submitted to substantiate any information provided in this field.
_____
_____
_____

*25. REQUESTNG PROVIDER INFORMATION
NAME: _____
ADDRESS: _____
_____
NPI#: _____
PHONE: (_____) _____FAX: (____) _____
OFFICE CONTACT NAME: _____

26. HOSPITAL/FACILITY INFORMATION (Required if facility will be billing)
NAME: _____
ADDRESS: _____
_____
NPI#: _____
PHONE: (_____) _____FAX: (____) _____
OFFICE CONTACT NAME: _____

27. PRESCRIBING PROVIDER INFORMATION (If different from requesting provider)
NAME: _____ PHONE: (_____)_____

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.

*ASTERISK DENOTES A REQUIRED FIELD

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

15. MEDICAL SUPPLY, THERAPY, IMAGING OR PROCEDURE DESCRIPTION (Do not include codes from page 1)	16. CPT/HCPCS	17. MODIFIER	18. UNITS/VISITS	19. ESTIMATED COST
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				
12)				
13)				
14)				
15)				
16)				
17)				
18)				
19)				
20)				
21)				

NOTE: For DME repair or replacement requests, provide the information below for the item(s) that is being repaired or replaced. For items that have been repaired or replaced previously, enter the most recent date of repair or replacement.

DESCRIPTION OF DME ITEM	HCPCS CODE	DATE OF DELIVERY OF ITEM	QUANTITY
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			

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. **MEDICAID MEMBER ID** (Enter the entire 10 digit Utah Medicaid identification number of the member)
2. **MEDICAID MEMBER NAME**
3. **MEDICAID MEMBER DATE OF BIRTH**
4. **MEDICAID MEMBER AGE**
5. **MEDICAID MEMBER GENDER**
6. **HAS ELIGIBILITY BEEN VERIFIED?** (Member eligibility must be verified prior to submitting PA requests)
7. **IS THE MEMBER ENROLLED IN AN MCO?** (Unless service is a carve out, the request must be submitted to the MCO directly)
8. **DOES THE SERVICE CODE BEING REQUESTED REQUIRE PRIOR AUTHORIZATION?** (Must be verified prior to submission of request)
9. **DATE OF REQUEST** (Date of request submission, including all required documentation)
10. **REQUESTED DATE(S) OF SERIVCE**
11. **RETROACTIVE REQUEST** (All retroactive requests require a reason. Please see the Section 1 Provider Manual for allowable reasons)
12. **CHANGE TO AN EXISTING PA** (Must include the previous PA # if this request is for a change to an existing PA)
13. **NUMBER OF PAGES INCLUDED WITH REQUEST**
14. **IS THIS REQUEST FOR HOME HEALTH SERVICES?** (All requests for home health services must indicate provider type or request will not be processed)
15. **REQUESTED MEDICAL, THERAPY, IMAGING OR PROCEDURE DESCRIPTION** (Up to 3 entries may be made on page 1, for additional entries please use page 2)
16. **REQUESTED CPT/HCPCS CODE** (Up to 3 entries may be made on page 1, for additional entries please use page 2)
17. **MODIFIER** (Required to indicate rental or purchase, technical or professional component, right or left, etc.)
18. **UNITS/VISITS**
19. ESTIMATED COST (Enter estimated cost for DME or Medical supplies)
20. **DIAGNOSIS DESCRIPTION & ICD-10-CM CODE(S)**
21. WILL THE SERVICE OF AN ANESTHESIOLOGIST BE USED? (Required for surgical procedures)
22. **IS THIS A REQUEST FOR A MEMBER IN A SKILLED NURSING FACILITY?** (If yes, name and phone number of facility are required)
23. DOES THE MEMBER HAVE A COURT APPOINTED LEGAL GUARDIAN? (Required for primary sterilization procedures, e.g. tubal ligation, vasectomy)
24. SUMMARY OF HISTORY (Information from the patient's medical record must be submitted to substantiate any information entered in this field)
25. **REQUESTING PROVIDER INFORMATION** (Information of the provider that is submitting the PA request)
26. HOSPITAL/FACILITY INFORMATION (This information is only required if the hospital/facility will be billing Medicaid for the services requested)
27. PRESCRIBING PROVIDER INFORMATION (Required for items that need a valid order (e.g. DME, Medical Supplies, etc.)

NOTE: Requests that are sent to an incorrect fax number will not be processed. Always verify fax number prior to submission of protected health information.

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

Outpatient Therapies (Speech, Occupational & Physical) ... **(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**

Personal Care ..... **(801)536-0157**

All other requests .....**Call PA staff for fax numbers not listed**

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**