

UTAH MEDICAID PUBLICATION OR FORM REQUEST

**** Remittance and Warrant Tracers are not to be requested prior to 30 days from the date of payment.
** Please Allow 7-10 Business Days for Processing.**

PROVIDER INFORMATION

_____	_____	_____
Attention:	Billing Company Name	Phone #
_____		_____
Facility Name (Required)	NPI (Required)	
_____		_____
Address (Required)	Suite	
_____		_____
City (Required)	State (Required)	ZIP Code (Required)
_____		_____
E-mail Address	Tax ID Number (Required)	

Remittance Request (One Provider Per Worksheet)
** If the Remittance Request is being sent US Mail and is over 25 pages, then a charge of \$0.12 will be charged for each additional page. Payment must be received before the remittance will be sent out.

_____	_____	_____	_____
Run Date (Required)	Warrant # (Required)	Amount	Provider Contract #

_____	_____	_____	_____
Run Date (Required)	Warrant # (Required)	Amount	Provider Contract #

_____	_____	_____	_____
Run Date (Required)	Warrant # (Required)	Amount	Provider Contract #

Warrant Tracer (Paper Checks)

_____	_____	_____
Warrant Date (Not Run Date)	Warrant # (Required)	Warrant Amount Required

_____	_____	_____
Warrant Date (Not Run Date)	Warrant # (Required)	Warrant Amount Required

_____	_____	_____
Warrant Date (Not Run Date)	Warrant # (Required)	Warrant Amount Required

IHC Access Request

Fee Schedule Request **TM** **NTM** **PCN** (Select Program which applies)

_____	Physician	_____	Medical Supply	_____	Physical Therapy	_____	Other _____
_____	Dental	_____	Home Health	_____	Audiology	_____	(please specify) _____
_____	Vision	_____	Podiatry	_____		_____	

Publication/Form Request

_____ 499-A Sterilization / Hysterectomy Consent

_____ Medicaid Information Bulletin Number (or Name): _____

_____ PA-3 Prior Authorization

_____ Disclosure of Information (Client) To/From (Circle)

_____ Other Publication: _____

Manuals listed on back of form

Return Document Request Form by mail or fax to:

**Bureau of Medicaid Operation
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0476**

CHECK PLAN REQUESTED

TRADITIONAL MEDICAID PLAN NON-TRADITIONAL MEDICAID PLAN PCN (PRIMARY CARE NETWORK)

INDICATE TYPE OF MANUAL/SECTION BY CIRCLING OR A CHECK

Table of Contents/Welcome Section 1 Section 2,3,4 General Attachments

Audiologist
Child Health Evaluation Care: CHEC
Certified Nurse Midwife
Chiropractor
Dental Care
Diagnostic & Rehabilitative Mental Health Services by DHS Contractors
Enhanced Services for Pregnant Women
Home and Community Waiver Programs for Individuals

- Aged 65 and over
- With Brain Injury, Age 18 and Over
- With Developmental Disabilities
- With Physical Disabilities
- Technology Dependent Children

Home Health Agency
Hospice
Hospital (includes Birthing Center, End Stage Renal Disease, Free-standing Ambulatory Surgical Center)
Laboratory
Long Term Care
Medical Transportation
Medical Supplies
Mental Health Center
Nurse Practitioner (Family/Pediatric)
Occupational Therapy Services by an Independent O.T. NOT in a Rehabilitation Center
Oral Surgeon
Personal Care
Pharmacy
Physical Therapy and Occupational Therapy Services in a Rehabilitation Center
Physical Therapy Services by an Independent P.T. NOT in Rehabilitation Center
Physician (includes Anesthesiology, Laboratory Services)
Podiatric Services
Psychologist
Rural Health Clinic
School Based Skills Development Services
Speech Pathology
Substance Abuse Services Provider
Targeted Case Management Programs for:

- AIDS Patients
- CHEC Eligibles
- Chronically Mentally Ill
- Early Childhood Development
- Homeless
- Substance Abuse Services

Vision Care

**Manuals are available on the Internet at <http://health.utah.gov/medicaid/>

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