

# UTAH MEDICAID

## REMITTANCE ADVICE REQUEST FORM

**\*\* Remittance Advices are not to be requested prior to 30 days from the date of payment. Please Allow 7-10 business days for processing.**

### REQUESTOR INFORMATION

\_\_\_\_\_  
Name (PRINT) (Required)

\_\_\_\_\_  
Title (Required)

\_\_\_\_\_  
Billing Company Name (if applicable)

(\_\_\_\_\_)\_\_\_\_\_  
Phone # (Required)

\_\_\_\_\_  
E-mail Address (Required)

Attestation: I declare under penalty of perjury that I am an authorized agent of the provider listed below, and therefore am entitled to receive the Remittance Advice or Health Care Claim Payment/Advice (835) transaction covered under HIPAA Privacy rules and regulations pertaining to release of Personal Health Information/Personally Identifiable Information (PHI/PII) information.

\_\_\_\_\_  
Signature (Required)

\_\_\_\_\_  
Date (Required)

### PROVIDER INFORMATION

\_\_\_\_\_  
Provider/Facility Name (Required)

\_\_\_\_\_  
NPI/Contract Number-Atypical (Required)

\_\_\_\_\_  
Tax ID Number (Required)

\_\_\_\_\_  
Contact Name (Required)

(\_\_\_\_\_)\_\_\_\_\_  
Phone Number (Required)

\_\_\_\_\_  
Address (Required)

\_\_\_\_\_  
Suite

\_\_\_\_\_  
City (Required)

\_\_\_\_\_  
State (Required)

\_\_\_\_\_  
ZIP Code (Required)

One Provider Per Worksheet

\*\* If the Remittance Advice requested is being sent via US Mail and is over 25 pages, a charge of \$0.12 will be assessed for each additional page. Payment must be received before the remittance is mailed out.

\_\_\_\_\_  
Run Date (Required)

\_\_\_\_\_  
Warrant Number (Required)

\_\_\_\_\_  
Amount

\_\_\_\_\_  
Run Date (Required)

\_\_\_\_\_  
Warrant Number (Required)

\_\_\_\_\_  
Amount

\_\_\_\_\_  
Run Date (Required)

\_\_\_\_\_  
Warrant Number (Required)

\_\_\_\_\_  
Amount

\_\_\_\_\_  
Run Date (Required)

\_\_\_\_\_  
Warrant Number (Required)

\_\_\_\_\_  
Amount

\_\_\_\_\_  
Run Date (Required)

\_\_\_\_\_  
Warrant Number (Required)

\_\_\_\_\_  
Amount

**For Official Use Only:**

Action Taken: \_\_\_\_\_

\_\_\_\_\_  
Name / Date

**Return Remittance Advice Request Form by mail or fax to:**

**Bureau of Medicaid Operations  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Fax: (801) 536-0498**