Utah Medicaid Provider Manual
Division of Medicaid and Health Financing

Request for Prior Authorization
Updated April 2011

FORM NUMBER
24 06 37
UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

DO NOT USE THIS FORM FOR MOLINA OR HEALTHY U REQUESTS. PLEASE CONTACT THE MCO FOR PA REQUEST INSTRUCTIONS

1. DATE OF REQUEST:_____ **2.**REQUESTED DATE(S) OF SERVICE: _____ - _____ **3.** RETROACTIVE REQUEST: □ YES □ NO **4.** REQUEST CHANGE TO A CURRENT PA: □NO □ YES PA #_____ **5.** NUMBER OF PAGES INCLUDED WITH REQUEST:_____	**FAX THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO THE APPROPRIATE NUMBER ON THE ATTACHED INSTRUCTIONS PAGE** **OR MAIL TO:** **UTAH MEDICAID PRIOR AUTHORIZATION UNIT** **PO BOX 143111** **SALT LAKE CITY, UT 84114-3111** FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS , PLEASE CALL: **(801) 538-6155** OPTIONS **3, 3**

6. Patient Name: Last, First, M.I.	7. Date of Birth	8. Age	9. Sex □ Male □ Female	10. Medicaid ID #

11. Medical Supply, Therapy, Imaging or Procedure Requested *(List primary procedure first)*	12. CPT , Medical Supply or Surgical Code	13. Units/Visits Requested	14. Estimated Cost
1)			
2)			
3)			

15. Will the service of an Anesthesiologist be used?	16. Will the service of an Assistant Surgeon be used?
□ Yes □ No	□ Yes □ No

A. **Is the above patient in an institution?** □ Yes □ No
B. **Does the above patient have an intellectual disability?** □ Yes □ No
C. **Is the above patient in nursing facility?** □ Yes □ No
D. **Does the above patient have a mental illness?** □ Yes □ No

17. Hospital/Facility Name, Address and NPI #

Name_____

Address _____

_____

Phone # (_____)_____

NPI # _____

18. Diagnosis Description & ICD-9-CM Code(s)

_____

_____

_____

_____

19. 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)

_____

_____

_____

_____

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

Name_____

Address _____

_____

Phone (____)_____Fax (____)_____

Office Contact Name_____

NPI # _____

21. 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.

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MEDICAL SERVICES FORM

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

PATIENT NAME:_____ MEDICAID ID #_____

11. Medical Supply, Therapy, Imaging or Procedure Requested *(Do not include codes from page 1)*	12. CPT , Medical Supply or Surgical Code	13. Units Requested	14. 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. **Patient name**
7. **Date of birth**
8. **Age**
9. **Sex**
10. **Medicaid ID #** (Enter the entire 10 digit Medicaid Identification Number of recipient)
11. **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")
12. **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")
13. **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)
14. Estimated cost (Enter estimated cost for supply/drug/therapy/procedure requested)
15. Will Services of an anesthesiologist be used?
16. Will assistant surgeon be used?
17. **Hospital/facility name & address: include street address, city, state and zip code and facility NPI#.**
18. **Diagnosis description & ICD-9-CM code**
19. SUMMARY OF HISTORY (Enter a narrative description of the patient's history)
20. **Name/address/contact information and NPI# of requesting or supplying provider:**
21. **Name/address/contact information of referring or prescribing provider**

PLEASE FAX PRIOR AUTHORIZATION REQUESTS AND ANY ATTACHMENTS TO THE NUMBERS BELOW:	IF FAX IS NOT AVAILABLE, MAIL THE ORIGINAL COMPLETED FORM AND ANY ATTACHMENTS TO:
Outpatient Therapies (Speech, Occupational & Physical) & Diabetic Teaching……**(801)536-0491** Sleep Studies, Hyperbaric Oxygen Therapy , CPAP/BiPap & Supplies……**(801)536-0167** 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** MRI……**(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**	MEDICAID PRIOR AUTHORIZATION BOX 843111-3111 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**