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: TruMobility
ADDRESS: 272 S 671 W
Pleasant Grove, UT 84062
NPI#: 1497126486
PHONE: (801) 607-1050 FAX: (801) 772-2710
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