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

Fax to # 801-536-0958

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 # N/A

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) Description of Code	Code	(i.e. 4 quads SRP)	$928.00
2)			
3)			

15. Will the service of an Anesthesiologist be used?
☐ Yes ☑ No

16. Will the service of an Assistant Surgeon be used?
☐ 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 Cascade Family Dental
Address _____
_____
Phone # (____) _____
NPI # Use treating doctor's 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.