HEALTH CO-OP

HEALTH PLANS
UNIVERSITY OF UTAH

Prior Authorization Request Form

2019

For a better experience, complete your request here: https://app.secure.uuhsc.utah.edu/umHealthPlans/main
Or you may fax your request: 801-213-1358. Please include this document at the front of your submission.

Our goal is to provide the most appropriate and timely care for our mutual patients. To this end, "**Urgent**" is defined as: Medical services that are needed in a timely or urgent manner that would subject the member to adverse health consequences without the care or treatment requested. University of Utah Health Plans reserves the right to classify Urgent requests as standard requests when this definition is not met.

Date of Request: 10/11/2019 Scheduled Start Date: _____ End Date: _____

Routine: ◯ Urgent: ◯ If urgent, give reason:_____

Outpatient: ◯ Inpatient: ◯ Number of pages:_____ Referral #:

Urgent requests will be completed in 72 hours and standard requests will be completed in 14 calendar days when all required documentation is received.
To provide better patient care and to avoid delays, submit a fully completed form and complete clinical documentation. Failure to submit required documentation may result in processing delays, the inability to establish medical necessity, and possibly a denial.

Patient name:_____ **DOB:** _____ **ID#** _____

Procedures	ICD-10	CPT Codes	Units/Visits	Estimated Costs

Requesting Physician: _____ NPI: _____

Contact Name: _____ Phone #: _____ Fax #: _____

Address: _____

Service Rendering Hospital/Facility: _____ TIN/NPI:_____

Contact Name: _____ Phone #: _____ Fax #: _____

Address: _____

Service Rendering Physician: _____ NPI: _____

Contact Name: _____ Phone #: _____ Fax #: _____

	Inpatient Amissions
	Admitting Orders, H&P, ED documentation, Labs, Imaging Results and Medications
	Procedure/Imaging Clinical Documentation Needed
	Physician notes - physical statement, detailed physical exam on affected site, radiological findings, Lab results, specific indication and other pertinent information related to the request
	NSAID usage, physical therapy and all other medical modalities tried - start and end time and the effectiveness of the medication, other modalities, and PT services (for imaging request)
	Consent form - Sterilization procedure, Hysterectomy acknowledgment form **Medicaid only**
	Bariatric Surgery Documentation Items Needed (CPT Codes 43644, 43846, 43770)
	Commitment of patient to comply with treatment/knowledge of -- daily exercise, dietary compliance, willingness to continue supervised behavior modification therapy for a year.
	Psychological evaluation, social support system, willingness/motivation to comply with requirements, understanding of surgical risk/teaching, post op compliance
	H&P with obesity history. Dietary history, length of time >3 years, BMI >35 and <40 with comorbidity (one), type 2 DM, HTN, CAD/CHF/dyslipidemia, OSA,GERD, osteoarthritis, pseudotumor cerebri
	Medically supervised weight loss >3 months
	Power or Custom Wheelchair Documentation Needed
	Current wheelchair type, date of purchase, and purchaser(insurance, private)
	Clinical evaluation by patient's PCP addressing ambulatory ability, prognosis, in LOMN form
	Wheelchair evaluation by PT/OT within 6 months for clients 21 and older; Shriners and primary Children's are affiliates within 3 months for under 21
	Patient skills check list for power chair, Barriers to transport, use/accessibility of residents have been addressed, Repair history of current wheelchair if applicable

Please access the links below for Medicaid forms, Manuals, and Criteria.
http://health.utah.gov/Medicaid/provhtml/forms.htm
http://health.utah.gov/Medicaid/manuals/directory.php
http://health.utah.gov/Medicaid/pa/index.html