

Utah Medicaid Prior Authorization Request for Hospice Services

Hospice Provider Name:	
NPI Provider Number:	
Initial Hospice Admission Date: (No matter the funding source)	
Is the client Medicaid eligible upon initial admission?	<input type="checkbox"/> Yes (Submit <u>this form</u> and copies of the <u>signed election statement</u> and <u>plan of care</u> to Medicaid within 10 calendar days. If this form is not received timely, Medicaid will not reimburse for hospice services rendered prior to the date the PA request is received.)
	<input type="checkbox"/> No (Complete <u>this form</u> & attach copies of the <u>initial care plan</u> and <u>signed election statement</u> but DO NOT submit anything to Medicaid until after client becomes Medicaid eligible. Medicaid will then require all three documents when determining post payment authorization up to 90 days retroactive.)
Who Signed the Election Statement?	<input type="checkbox"/> Client <input type="checkbox"/> Legal Representative as defined in R414-14A
Client's Name:	Last: _____ First: _____
Medicaid ID Number:	
Social Security Number:	
Date of Birth:	
Diagnosis(es) Description: (Not codes)	
Hospice Plan of Care:	(Copy required)
Physician:	Last: _____ First: _____
Hospice Contact Person:	
Contact Person Phone Number:	
Date of Retro Medicaid Eligibility:	
Nursing Home Name:	
Hospice Benefit Requested:	<input type="checkbox"/> Routine <input type="checkbox"/> Room & Board <input type="checkbox"/> Other _____
Prior Auth Effective Dates:	_____ to _____ PA # _____
	_____ to _____ PA # _____
Discharge date: ____/____/____ <ul style="list-style-type: none"> • Call in to: 801-538-6634 • Or fax to: 801-536-0157 	Date of death: ____/____/____ Date client revoked: ____/____/____ (Send a copy of the revocation form signed by the client or legal representative.)

**Please note: This form is effective July 1, 2010. No other forms will be accepted after this date.
The Department will not accept PA request forms that have been modified in any way.**