HEALTH | CHOICE
UTAH

UM Prior Authorization Request form

For a better experience, if you are a contracted provider, we invite you to register to our provider portal. If not, please use our website to submit your request directly.
https://apps.uhealthplan.utah.edu/UHealthPlansForms/Authorization/Create

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, "**Expedited**" 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: _____ Scheduled Start Date: _____ End Date: _____

Routine: ◯ Expedited: ◯ If expedited, (scheduling excluded), please provide medical reason:_____

Number of pages: _____ _____

Expedited requests will be completed within 72 hours and standard requests will be completed within 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

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 #: _____

Bariatric Surgery Documentation Items Needed:	
	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
CPAP/ Bi-PAP Documentation needed for ongoing rental:	
	Compliance report
	Face to Face follow-up
Genetic Testing Documentation Needed:	
	Evidence of how the testing will affect the plan of care
Home Health Documentation Needed:	
	Plan of care (POC) 485 Form for Home Health
Hospice Documentation Needed:	
	Plan of care (POC) 485/487 Form for Home Health Items Needed
	Certification of Terminal Illness signed by the provider prior to initiation of Hospice
	Signed Consent and Election by the Member or Responsible party
Outpatient Rehabilitation Documentation Needed:	
	Initial Evaluation
	Clinicals of the most recent 5 visits
	Re-evaluation
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
Magnetic Resonance Imaging (MRI)	
	UUHP requires prior authorization for MRIs. To determine medical necessity, supporting clinical documentation must be submitted. Documentation must include Office Visit Notes and/or Progress Notes including, but not limited to: physical exam, abnormal findings, duration of symptoms, and previous failed conservative treatments.

Private Duty Nursing (PDN) Documentation Needed:	
	Private Duty Nursing Acuity Grid
	Flow sheets of skills, medication administration records
	Last two weeks of skilled nursing notes
Transcranial Magnetic Stimulation (TMS) Documentation Needed	
	Documentation of at least 2 antidepressants trials over 6 weeks from two different classes in the current episode
	Written documentation of an inability to tolerate antidepressant agents as evidenced by four or more lifetime trials with distinctive side effects
	No contraindications to repetitive TMS (rTMS)
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 Physical/Occupational Therapy 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 Utah Medicaid Website for any Medicaid forms, manuals, and/or Criteria.