HEALTH | CHOICE
UTAH

Residential Treatment Services Prior Authorization Request Form

<table>
<tr><td>1.Today's Date:</td><td rowspan="3">SUBMIT THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO ONE OF THE FOLLOWING:

FAX: 1-801-587-4855

EMAIL:
InpatientNotification@healthchoiceutah.com

MAIL:
Health Choice Utah
PO Box 45900
Salt Lake City, Ut 84145</td></tr>
<tr><td>2.Original Date of Admission to Treatment Center:</td></tr>
<tr><td>3.Requested Dates of Authorization (date span must match total days requested below):</td></tr>
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Medicaid Member Information	
4.Member Name:	**5.Medicaid ID#:**
6.Date of Birth:	

Servicing Provider Information		
7.Provider Name:	**8.Provider NPI #:**	
9.Provider Address: ______ ______ ______	**10.Provider Phone Number:** (___) ______ Ext. ___ Office Contact Name: ______	**11.Provider Fax Number:** ______ Ext. ___ Provider Email: ______

12.Requested Service	**Total Days Requested**
H0018 – (17 or more beds) Behavioral Health; short-term residential (non-hospital residential treatment program), without room and board, per diem (Alcohol and/or drug services).	
H2036 – (16 or less beds) Behavioral Health; short-term residential (non-hospital residential treatment program), without room and board, per diem (Alcohol and/or drug services).	

19. Comments (Optional)