UM Request Fax Cover Sheet

Date of Request: ___________________________

Scheduled date: ___________________________

Urgent request/reason: ____________________

Of pages included in request: ______________

Mail to: P.O. Box 45180, Salt Lake City, Utah 84145

Fax to: 801-281-6121

Phone: 888-271-5870 or 801-587-6480

Email: uuhp_um@hsc.utah.edu

Patient name: ___________________________________ **DOB:** ____________________ **ID#**_________________________

Procedure	ICD-9	CPT code	Units/visits	Estimated cost
1)				
2)				
3)				
4)				

Requesting Physician/Agency: ___________________________

Address: ____

Contact: ____

Phone: ____

FAX: ____

Service Rendering Hospital/facility:

____

Service Rendering Physician: ___________________________

X	PROCEDURE/IMAGING CLINCAL DOCUMENTATION NEEDED
☐	Physician notes –physician 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 & all other medical modalities tried —start and end time and the effectiveness of the medication, other modalities, & PT services (for Imaging request)
☐	Consent form-Sterilization procedure, Hysterectomy acknowledgement form

For Home Health Requests, please indicate services and include number requested and frequency:

X	HOME HEALTH SERVICE CODE	# OF UNITS	FREQUENCY	START DATE	END DATE
☐					
☐					
☐					
☐					
☐					
☐					
☐					

*Please also submit completed information below for applicable specific service requested :	
X	**HOME HEALTH SERVICES DOCUMENTATION NEEDED**
	INITIAL REQUEST
☐	Hospital discharge summary and orders **OR** physician note within 30 days prior to request documenting Medical necessity
☐	Completed 485/487 with plan of care *
☐	RN evaluation summary statement describing patient's current condition and limitations **NO OASIS ***
☐	Homebound status *
☐	Living arrangements *
☐	Care givers available *
☐	Waiver status if known
☐	Other community resources being used if known
☐	Therapy: Initial evaluation, plan of care, frequency and duration, measurable goals
	ONGOING REQUEST Starred (*) items above plus
☐	Last 2 weeks of Home Health Aide records if applicable
☐	Most current PCP clinical note if available. **Request may be denied for lack of information.**
☐	Therapy: progress note showing original goals and progress made
	PRIVATE DUTY NURSING T1000 request
☐	Last 2 weeks of skilled nursing notes
☐	Flow sheets for skills, medication administration records
☐	Private Duty Nursing Acuity Grid
X	**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 at least one year.
☐	Psychosocial 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 >6 months (AND)-- weight loss >10% in previous 6 months
☐	Consultations—cardiac, pulmonary, dietary, endocrine diseases excluded, peptic ulcer disease excluded by EGD or UGI or h. pylori negative, drug and alcohol sober >1year OR no abuse by history
X	**POWER OR CUSTOM WHEELCHAIR DOCUMENTATION NEEDED**
☐	Current wheelchair type, date of purchase, and purchaser (insurance, private)
☐	Clinical evaluation by patient's PCP addressing ambulation ability, prognosis, in LOMN form
☐	Wheelchair evaluation by PT/OT at UU hospital or Sugarhouse clinic WITHIN 6 MONTHS for clients 21 and older; Shriners Hospital or Primary Childrens and affiliates WITHIN 3 MONTHS for under 21
☐	Patient skills check list for power chair
☐	Barriers to use/accessibility of residence have been addressed
☐	Barriers to transport have been addressed
☐	Repair history of current wheel chair 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