

**Substance Use Disorder Residential Treatment Services
Prior Authorization Request Form**

1. Today's Date:		<p>SUBMIT THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO <u>ONE</u> OF THE FOLLOWING:</p> <p>FAX: 1-801-758-3370</p> <p>EMAIL: HCH.HCUHealthServices@steward.org</p> <p>MAIL: Steward Health Choice Utah 406 W South Jordan Parkway Suite 600 South Jordan, UT 84095 - 3333</p>	
2. Original Date of Admission to Treatment Center:			
3. Requested Dates of Authorization (date span must match total days requested below):			
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:	11. Provider Fax Number:	
_____	(____)_____ Ext. _____	(____)_____ Ext. _____	
_____	Office Contact Name:	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)			