UTAH MEDICAID
REMITTANCE ADVICE REQUEST FORM

A Remittance Advice Request Form will only be accepted for remittances received prior to April 2023. All other remittances can be found in PRISM or by calling their clearinghouse support vendor. Please review the FAQ found at: Provider FAQ: Electronic Data Interchange (EDI)

REQUESTOR INFORMATION

Name (PRINT) (*Required*) _____ Title (*Required*) _____

Billing Company Name (if applicable) _____ Phone # (*Required*) _____

E-mail Address (*Required*) _____

Attestation: I declare under penalty of perjury that I am an authorized agent of the provider listed below, and therefore am entitled to receive the Remittance Advice or Health Care Claim Payment/Advice (835) transaction covered under HIPAA Privacy rules and regulations pertaining to release of Personal Health Information/Personally Identifiable Information (PHI/PII) information.

Signature (*Required*) _____ Date (*Required*) _____

PROVIDER INFORMATION

Provider/Facility Name (*Required*) _____ NPI/Contract Number-Atypical (*Required*) _____

Tax ID Number *(Required)* _____ Contact Name *(Required)* _____ (_____)_____ Phone Number *(Required)*

Address (*Required*) _____ Suite _____

City (*Required*) _____ State *(Required)* _____ ZIP Code (*Required*) _____

One Provider Per Worksheet
** If the Remittance Advice requested is being sent via US Mail and is over 25 pages, a charge of $0.12 will be assessed for each additional page. Payment must be received before the remittance is mailed out.

Run Date (*Required*)	Warrant Number *(Required)*	Amount

For Official Use Only:

Action Taken: _____ _____
Name / Date

Return Document Request Form by mail or fax
to: Bureau of Medicaid Operations
PO Box 143106
Salt Lake City, UT 84114-3106
Fax: (801) 536-0498
Email: fax_remits_health@utah.gov