

UTAH STATE DEVELOPMENTAL CENTER REQUEST FOR SERVICES

TO AVOID DELAY IN REQUEST, PLEASE RESPOND COMPLETELY TO ALL AREAS

SERVICE(S) REQUESTED:

(Neurology, Psychiatric, Adaptive Wheelchair, Adaptive Equipment, Programmatic, etc.)

SERVICE REQUEST FOR:

Name:	Date of Birth:
Social Security #:	Telephone:
Address:	
Is the above individual currently receiving services from the Division of Services for People with Disabilities? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Type of service received:	

INSURANCE INFORMATION:

Name of Insurance Company(ies):	
ID#:	
Policy Holder:	
Medicaid #:	Medicare #:
Who will pay for services not covered by insurance?	
Billing Address:	
Telephone:	

PERSON REQUESTING SERVICES IF OTHER THAN ABOVE:

Name:	Title:
Address:	Telephone:
Relationship to patient (DSPD regional staff, ICF/MR, QMRP, other):	
When is the best time to contact you?	
Additional contact (Support Coordinator, QMRP, etc.):	
Telephone:	

LIST PRIVATE PROVIDERS PREVIOUSLY CONTACTED FOR REQUESTED SERVICES:

Name, Address and Telephone	Reason for Denied Services

*** AUTHORIZED SIGNATURES REQUIRED PRIOR TO SERVICE DELIVERY ***

*1) Region Director:

OR

Nursing Home Administrator:

*2) Developmental Center Medical Services Director:

*3) Developmental Center Administrator:

*4) Business Office:

DEVELOPMENTAL CENTER USE ONLY:	
Estimated cost of services:	
Contact made:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied (see attached)
Appointment schedule:	