

Indiana Health Coverage Programs Prior Authorization Request Form

Check the radio button of the entity that must authorize the service.
(For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

| Fee-for-Service | Gainwell Technologies | P: 1-800-457-4584, option 7 | F: 1-800-689-2759 |
|----------------------------|-------------------------------|-----------------------------|-------------------|
| Hoosier Healthwise | Anthem Hoosier Healthwise | P: 1-866-408-6132 | F: 1-866-406-2803 |
| | CareSource Hoosier Healthwise | P: 1-844-607-2831 | F: 1-844-432-8924 |
| | MDwise Hoosier Healthwise | P: 1-888-961-3100 | F: 1-888-465-5581 |
| | MHS Hoosier Healthwise | P: 1-877-647-4848 | F: 1-866-912-4245 |
| Healthy Indiana Plan (HIP) | Anthem HIP | P: 1-844-533-1995 | F: 1-866-406-2803 |
| | CareSource HIP | P: 1-844-607-2831 | F: 1-844-432-8924 |
| | MDwise HIP | P: 1-888-961-3100 | F: 1-866-613-1642 |
| | MHS HIP | P: 1-877-647-4848 | F: 1-866-912-4245 |
| Hoosier Care Connect | Anthem Hoosier Care Connect | P: 1-844-284-1798 | F: 1-866-406-2803 |
| | MHS Hoosier Care Connect | P: 1-877-647-4848 | F: 1-866-912-4245 |
| | UnitedHealthcare | P: 1-877-610-9785 | F: 1-844-897-6514 |

Please complete all appropriate fields.

| Patient Information | | | | | |
|--|--|-----|--|-----|--|
| IHCP Member ID (RID): | | | | | |
| Date of Birth: | | | | | |
| Patient Name: | | | | | |
| Address: | | | | | |
| City/State/ZIP Code: | | | | | |
| Patient/Guardian Phone: | | | | | |
| PMP Name: | | | | | |
| PMP NPI: | | | | | |
| PMP Phone: | | | | | |
| Ordering, Prescribing, or Referring (OPR) Provider Information | | | | | |
| OPR Physician NPI: | | | | | |
| Medical Diagnosis (Use of ICD Diagnostic Code Is Required) | | | | | |
| Dx1 | | Dx2 | | Dx3 | |

| Requesting Provider Information |
|---------------------------------------|
| Requesting Provider NPI/Provider ID: |
| Taxonomy: |
| Taxpayer Identification Number (TIN): |
| Provider Name: |
| Rendering Provider Information |
| Rendering Provider NPI/Provider ID: |
| TIN: |
| Name: |
| Address: |
| City/State/ZIP Code: |
| Phone: |
| Fax: |
| Preparer's Information |
| Name: |
| Phone: |
| Fax: |

Please check the requested assignment category below:

- | | | |
|------------------|----------------------|------------------|
| DME | Inpatient | Physical Therapy |
| <i>Purchased</i> | Observation | Speech Therapy |
| <i>Rented</i> | Office Visit | Transportation |
| Home Health | Occupational Therapy | Other |
| Hospice | Outpatient | |

| Dates of Service Start | Stop | Procedure/Service Codes | Modifiers | Service Description | Taxonomy | Place of Service (POS) | Units | Dollars |
|------------------------|------|-------------------------|-----------|---------------------|----------|------------------------|-------|---------|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____

See the [IHCP Quick Reference Guide](#) for information about where to mail this form.