Indiana Health Coverage Programs
Prior Authorization Request Form

Select 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	Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan (HIP)	Anthem HIP	P: 844-533-1995	F: 866-406-2803
	CareSource HIP	P: 844-607-2831	F: 844-432-8924
	MDwise HIP	P: 888-961-3100	F: 866-613-1642
	MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	UnitedHealthcare	P: 877-610-9785	F: 844-897-6514

Please complete all appropriate fields.

Patient Information

IHCP Member ID:

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 Provider NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)

Dx1		Dx2		Dx3	

Please check the requested assignment category below:

- DME
  - *Purchased*
  - *Rented*
- Home Health
- Hospice
- Inpatient
- Observation
- Office Visit
- Occupational Therapy
- Outpatient
- Physical Therapy
- Speech Therapy
- Transportation
- Other

Requesting Provider Information

Requesting Provider NPI/Provider ID:

Taxonomy:

Taxpayer Identification Number (TIN):

Provider Name:

Provider Address:

Rendering Provider Information

Rendering Provider NPI/Provider ID:

TIN:

Name:

Address:

City/State/ZIP Code:

Phone:

Fax:

Preparer's Information

Name:

Phone:

Fax:

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.