Prior Authorization

System Update Request Form

Date: ______________________

Requesting Provider Number: ______________________
Mail to Provider ID: ______________________
Service Location: ______________________
Provider Name: ______________________
Contact Person: ______________________
Phone: ______________________

Member Name: ______________________
Member ID (RID): ______________________
Prior Authorization #: ______________________
Service Code (CPT/Modifier/Taxonomy, HCPCS, ICD, and so forth):

____

Summary of requested action(s):

____

Change(s) prompting the system update request:

____

Prior Authorization Department Use Only

Reviewer: ______________________
Date System: ______________________
Update: ______________________

Decision and comments:

____

Mail to: http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx

A copy of the decision will be provided to the requesting provider and to the member.