

Indiana Health Coverage Programs Prior Authorization Request Form

Check the box of the plan in which the member is enrolled.

Traditional	<input type="checkbox"/> Advantage Traditional	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	<input type="checkbox"/> Anthem Hoosier Healthwise	P: 866-408-7187	F: 866-406-2803
	<input type="checkbox"/> Anthem HHW – SFHN	P: 800-291-4140	F: 800-747-3693
	<input type="checkbox"/> MDwise Hoosier Healthwise	See www.mdwise.org	
	<input type="checkbox"/> MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan	<input type="checkbox"/> Anthem HIP	P: 866-398-1922	F: 866-406-2803
	<input type="checkbox"/> MDwise HIP	See www.mdwise.org	
	<input type="checkbox"/> MHS HIP	P: 877-647-4848	F: 866-912-4245
Care Select	<input type="checkbox"/> Advantage Care Select	P: 800-784-3981	F: 800-689-2759
	<input type="checkbox"/> MDwise Care Select	P: 866-440-2449	F: 877-822-7186

Please complete all appropriate fields.

Patient Information					
Medicaid ID/RID#:					
DOB:					
Patient Name:					
Address:					
City/State/Zip:					
Patient/Guardian Phone:					
PMP Name:					
PMP NPI:					
PMP Phone:					
Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

Requesting Provider Information:
NPI#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Ordering Physician NPI#:
Tax ID#:
Name
Address:
City/State/Zip:
Phone:
Fax:
Preparer's Information:
Name:
Phone:
Fax:

Please check the requested assignment category below:

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DME | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Purchased | <input type="checkbox"/> Observation | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Rented | <input type="checkbox"/> Office Visit | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |

Dates of Service Start	Dates of Service Stop	Procedure/Service Codes	Modifier(s)	Requested Service	Taxonomy	POS	Units	Dollars

Notes:

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

Signature of Qualified Practitioner _____ Date: _____