



Field	Description
Medical Diagnosis <ul style="list-style-type: none"> <li>Dx1</li> <li>Dx2</li> <li>Dx3</li> </ul>	Enter the primary, secondary, and tertiary International Classification of Diseases (ICD) diagnosis codes.
Assignment Category	Check the assignment category for the service you are requesting.
Dates of Service, Start	Enter the requested start date of service. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested stop date of service.
Procedure/Service Codes	Enter the requested service codes (such as Current Procedural Terminology (CPT <sup>®1</sup> ), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC), and so forth.
Modifiers	Enter any applicable service code modifiers.
Service Description	Enter a short description (or include an attachment) of the requested services and like services provided by other payers.
Taxonomy	Enter any applicable taxonomy codes.
POS	Enter the requested place of service (POS) code.
Units	Enter the requested number of units. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. <b>Required for home health services and durable medical equipment (DME) requests.</b>
Notes	Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan-of-treatment dates. Your request <b>MUST</b> include medical documentation to be reviewed for medical necessity.
Signature of Qualified Practitioner	Authorized provider, as listed in the <i>Provider Types Allowed to Submit PA Requests</i> section of the <a href="#">Prior Authorization</a> module and <i>405 IAC 5-3-10</i> , must sign and date the form. Signature stamps can be used. <b>Required.</b>
Date	

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