

Indiana Health Coverage Programs Prior Authorization Request Form

Check the box of the entity that must authorize the service (for managed care, check the member's plan unless the service is delivered as fee-for-service).

Fee-for-Service	Cooperative Managed Care Services (CMCS)	P: 800-269-5720	F: 800-689-2759
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-7187	F: 866-406-2803
	Anthem Hoosier Healthwise – SFHN	P: 800-291-4140	F: 800-747-3693
	MDwise Hoosier Healthwise	See www.mdwise.org	
	MHS Hoosier Healthwise	P: 877-647-4848	F: 866-912-4245
Healthy Indiana Plan	Anthem HIP	P: 866-398-1922	F: 866-406-2803
	MDwise HIP	See www.mdwise.org	
	MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 866-408-7187	F: 866-406-2803
	MDwise Hoosier Care Connect	P: 844-293-6309	F: 844-407-6454
	MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245

Please complete all appropriate fields.

Patient Information				
Medicaid ID/RID#:				
DOB:				
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#:
Tax ID#:
Service Location Code:
Provider Name:
Rendering Provider Information
Rendering Provider NPI#:
Tax ID#:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:
Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:

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

Dates of Service Start	Stop	Procedure/Service Codes	Modifiers	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: _____