Indiana University Health

Indiana University Health Medical Management Authorization Request Form

Forward completed form via FAX to IUHMM at (317) 962-6219

****Please complete all fields for review****

REQUESTING PHYSICIAN INFORMATION

Ordering MD: _____

****TAX ID**: _____

Address: _____

Phone: _____ Fax: _____

Contact: _____

REQUESTING VENDOR INFORMATION

Vendor: _____

****TAX ID**: _____

Address: _____

Phone: _____ Fax: _____

Contact: _____

MEMBER INFORMATION

Name: _____

ID#: _____

DOB: _____/_____/_____

SS#: _____/_____/_____

Phone: _____

******IUHMM USE ONLY******

AUTHORIZATION NUMBER_____

□ Services **APPROVED** As Requested
□ Request **MODIFIED** (see below for detail)
□ Request **DENIED**, Letter To Follow

Modifications Made:_____
IUHMM Staff:_____
Date:_____

Date of Service	CPT or HCPC Code	Requested Service	Place of Service + INP OP OBS	Units	Diagnosis / ICD9 Code

CLINICAL SUMMARY (Form will be *rejected* if CLINICAL SUMMARY is NOT completed). (Send attachments, if needed).

SIGNATURE OF REQUESTING MD: _____ **DATE**: _____