Prior Authorization Request Form for Health Care Services for Use in Indiana

Section I — Submission

Issuer Name	Phone	Fax	Date and Time Submitted _____am/pm ET/CT

Section II — General Information

Review Type □ Non Urgent □ Urgent	Clinical reason for urgency
Request Type □ Initial Request	□ Extension/Renewal/Amendment (Prev. Auth. #:)

Section III — Patient Information

Name	Patient Contact Phone	DOB	Sex □ Male □ Female ☐ Unknown
Subscriber Name (if different)	Member or Medicaid ID #	Group #	

Section IV — Provider Information

Requesting Provider or Facility		*Service Provider or Facility*	
Name		Name	
NPI #	Specialty	NPI #	Specialty
Phone	Fax	Phone	Fax
Contact Name and Phone		Name of Primary Care Provider (see instructions)	
Requesting Provider's signature and date (if required)		Phone	Fax

Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Planned Service or Procedure	*Code*	*Start Date*	*End Date*	*Diagnosis Description (ICD Version ____), if available*	*Code*

□ Inpatient □ Outpatient □ Provider Office □ Observation □ Home □ Day Surgery □ Other (specify)

□ Physical Therapy □ Occupational Therapy □ Speech Therapy □ Cardiac Rehab □ Mental Health/Substance Abuse

Number of sessions Duration Frequency Other

□ Home Health (MD signed Order attached? □ Yes □ No) (Nursing Assessment attached? □ Yes □ No)

Number of visits requested Duration Frequency Other

□ DME (MD signed order attached? □ Yes □ No) (*Medicaid only:* Title 19 Certification attached? □ Yes □ No)

Equipment/supplies (Include any HCPCS Codes) Duration

Section VI — Clinical Documentation (See Instructions Page, Section VI)

An issuer needing more information may call the requesting provider or authorized representative directly at: _____ _____ (ext. _____) or via email at _____. Preferred method of contact is □ phone or □ email.

Section VII — Reason for Denial or Partial Denial (To be completed by the issuer)