

# MDwise Community Healthcare System

## HIP USE ONLY

### Referral / Pre-Authorization form

Phone (219) 392-7072 Fax (219) 392-7090

**FORM MUST BE COMPLETED ENTIRELY OR WILL BE RETURNED**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Patient ID #:** \_\_\_\_\_

PMP Name: _____ IHCP#: _____  Address: _____  Phone: _____ Fax: _____ Signature: _____ <b>N</b>	<input type="checkbox"/> In Network <input type="checkbox"/> Out Of Network Specialist Name: _____ Specialty: _____ IHCP#: _____ Address: _____  Phone: _____ Fax: _____
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Diagnosis: \_\_\_\_\_ DxCode: \_\_\_\_\_ Procedure Code: \_\_\_\_\_

Reason for Request/Symptoms/Previous Treatment: \_\_\_\_\_

This referral does not authorize benefits for non-covered services.

<input type="checkbox"/> Chemotherapy/Radiation Oncology <input type="checkbox"/> Dialysis <input type="checkbox"/> DME (over \$500) <input type="checkbox"/> Orthotics/Prosthetics (over\$500) <input type="checkbox"/> Home Health Care <input type="checkbox"/> Hospice	<input type="checkbox"/> Inpatient Hospital Services Adm Date _____ Dis Date _____ <input type="checkbox"/> Pain Management <input type="checkbox"/> Outpatient Hospital Diagnostic Service <input type="checkbox"/> Physician Office # Visits: _____ <input type="checkbox"/> Plastic /Reconstructive Services	<input type="checkbox"/> Rehabilitation Services (PT/OT/ST) <input type="checkbox"/> SNF Confinement <input type="checkbox"/> Same Day Surgery <input type="checkbox"/> Transplant Work-up <input type="checkbox"/> Other: _____
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SERVICES AUTHORIZED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Service is:  Elective  Urgent  Emergent

**E FAX THIS FORM TO (219) 392-7090**

<p style="text-align: center;"><b>APPROVAL</b></p> Approved for: _____ _____ # of units authorized: _____ Auth #: _____ Signature of Reviewer: _____ Date: _____	<p style="text-align: center;"><b>NON-APPROVAL</b></p> Reason: _____ _____ _____ Signature of Reviewer: _____ Date: _____
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HIP Claims Address: MDwise (HIP) P.O. Box 33049 Indianapolis, IN 46203 Payor ID: MDWIS
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**Signature**