

IUMG PRIOR AUTHORIZATION REQUEST FORM

Fax to: 317-860-2734 or 317-860-2735

For Medicaid RBMC Wishard MDwise Programs: Inpatient Admission,
23 Hour Observation, Outpatient Surgery, IV Drugs, Equipment, Home Health, OT/PT/ST

PLEASE NOTE - YOUR REQUEST **MUST** INCLUDE MEDICAL DOCUMENTATION TO BE PROCESSED!

PATIENT NAME: _____ (Last) (First) (Middle) DOB: ____ / ____ / ____ Guardian(s): _____	*THIS BOX FOR IUMG USE ONLY* Form Received: ____ / ____ / ____ Case Manager Opening Case: _____ Date Medical Info Requested: ____ / ____ / ____ Date Medical Info Received: ____ / ____ / ____ Date Sent to Physician/Reviewer: ____ / ____ / ____ Physician/Reviewer's Decision: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED Date of Decision : ____ / ____ / ____ Physician/Reviewer's Signature: _____ Tracking #: _____ Authorization #: _____ Denial #: _____ Denial Letter Sent/Faxed: ____ / ____ / ____ <input type="checkbox"/> Patient <input type="checkbox"/> PCP <input type="checkbox"/> Facility
Address _____ City _____ State _____ Zip _____ Member/Guardian PH #: _____	
MEDICAID ID/ RID#: _____ PCP Name: _____ PCP PH #: (____) _____ Name of Person Completing Form: _____ PH #: (____) _____ Fax #: (____) _____	
PATIENT REFERRED TO: _____ (First) (Last) ORDERING PHYSICIAN: _____ (First) (Last) PH #: (____) _____ Fax #: (____) _____ Appointment Date: ____ / ____ / ____ Admit Date: ____ / ____ / ____ Date of Surgery: ____ / ____ / ____	
DIAGNOSIS(ES): _____ ICD9: _____ ICD9: _____ ICD9: _____ PROCEDURE / SERVICE: _____ CPT: _____ CPT: _____ CPT: _____	
PLEASE CHECK THE APPROPRIATE BOX BELOW: <input type="checkbox"/> 23 HR OBS <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Home Health <input type="checkbox"/> Office Visit <input type="checkbox"/> Therapies: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST PLEASE SPECIFY FACILITY BY CHECKING THE APPROPRIATE BOX BELOW: <input type="checkbox"/> Wishard <input type="checkbox"/> IU <input type="checkbox"/> Riley <input type="checkbox"/> Methodist <input type="checkbox"/> St. Vincent (86 th St.) <input type="checkbox"/> St. Vincent Carmel <input type="checkbox"/> Other _____	
Requesting Provider Notes/Comments: _____ _____ MM Notes/Comments: _____ _____	
You Will Receive A Response To Your Fax Within 48 Hours Once All Medical Documentation Is Received QUESTIONS/CALL: 317-860-2736	