



# - PRIOR AUTHORIZATION REQUEST

*REFER TO NETWORK PROVIDER MANUAL FOR ITEMS REQUIRING PRIOR AUTHORIZATION*  
**Forward via FAX to MDwise Methodist Medical Management at (317) 705-3537 or 866-309-8741**

<b>1. REQUESTING PHYSICIAN INFORMATION</b> Ordering Physician: _____ Address: _____ Phone: _____ Fax: _____ Contact: _____	<b>2. REQUESTING VENDOR INFORMATION</b> Vendor: _____ Address: _____ Phone: _____ Fax: _____ Contact: _____
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**3. MEMBER INFORMATION**  
 Name: \_\_\_\_\_ RID #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_

**PLEASE NOTE: Any authorization is valid only if the member is eligible on the date service and this form is complete with a MDwise Medical Management staff signature.**

4. Date of Service	5. CPT Code or HCPC	6. REQUESTED SERVICE	7. Place of Service	8. UNITS	9. Diagnosis / ICD9 Code

**10. CLINICAL SUMMARY:** [Send attachment if applicable]

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\_\_\_\_\_

**THE CLINICAL SUMMARY MUST BE COMPLETED IN ORDER FOR REQUEST TO BE CONSIDERED. THIS FORM WILL BE REJECTED WITHOUT CLINICAL INFORMATION.**

**11. Signature of Requesting Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**12. FOR MDwise USE ONLY** **PA NUMBER** \_\_\_\_\_

Service Approved as Requested \_\_\_ **Request Modified** \_\_\_ **Request Denied, Letter to Follow** \_\_\_

**Modified from:** \_\_\_\_\_ **to** \_\_\_\_\_

**Rationale** \_\_\_\_\_

Person Notified of Denial \_\_\_\_\_ **Date** \_\_\_\_\_

PCC Signature \_\_\_\_\_ **Date** \_\_\_\_\_