



ProHealth
PRIOR AUTHORIZATION REQUEST

IF NOT COMPLETED IN FULL, REQUEST WILL BE RETURNED

Indianapolis Phone: (317) 621-7546 (800) 344-8672 Fax (317) 621-7984

Anderson Phone (765) 298-3020 Phone: (765) 298- 3021 Fax (765) 298-5859

Person submitting request: _____ Phone#: _____ Fax #: _____

Patient Name: _____ DOB: _____

RID#: _____ Network : PHI PHA

PMP Name: _____ PMP Phone # _____ PMP Fax # _____

Diagnosis: _____ ICD 9 Code(s): _____

Procedure: _____ CPT-4 Code(s): _____

Referred to: _____ Requested Service _____

Date of requested service _____ Requested Units/ Visits _____

Referred by: _____ Phone # _____ Fax# _____

SPECIALTY REFERRAL		
Specialist Name (MD Name): _____	Specialty: _____	
Requested Service _____	Service Type/ Vendor _____	
Date(s) of Service/ Procedure: _____		
Consult Only: <input type="checkbox"/>	Consult & Treat: <input type="checkbox"/>	Documentation Attached <input type="checkbox"/>

Additional Medical Information: _____

Referral Type: Self Referred: _____ Referred by PCP: _____ OON _____

If requesting approval for non-participating provider, indicate why participating provider cannot provide service

**PLEASE DO NOT WRITE BELOW THIS LINE
FOR PROHEALTH USE ONLY**

Authorization #: _____ # of Visits/ Units Approved: _____

Time Frame: ___/___/___ to ___/___/___

(Approval for consult & TX is valid for 90 days)

___ Urgent	___ Pre-Service	___ Concurrent
___ Non-Urgent	___ Post Service	___ Retrospective

Authorizing Agent: _____ Ext: _____ Date Submitted: _____

PH Med Director Decision:

- ___ Approved
- ___ Denied
- ___ Pended for further Research/information

Reason for Denial:

- ___ Not med necessary
- ___ Not a covered benefit
- ___ Svc available in network
- ___ Presenting symptoms Not meeting PLP guidelines
- ___ Other: see attached documentation

Reason for Approval:

- ___ Med necessity
- ___ Covered Benefit
- ___ Continuity of Care
- ___ Referred by PCP

Medical Director Signature _____ Date _____