

Date: _____

MDwise St. Catherine Network

Referral / Pre-Authorization form
Phone (219) 392-7072 Fax (219) 392-7090

Patient Name: _____ Date of Birth: _____ Patient ID #: _____

<p>PRIMARY MEDICAL PHYSICIAN:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Signature: _____</p>	<p>REFERRED TO:</p> <p><input type="checkbox"/> In-Network <input type="checkbox"/> Out of Network</p> <p>Name: _____</p> <p>Specialty: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>
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Diagnosis: _____ DxCode: _____ Procedure Code: _____

Reason for Referral/Symptoms/Previous Treatment: _____

SERVICE REQUESTED

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 \$250) <input type="checkbox"/> Orthotics/Prosthetics <input type="checkbox"/> Home Health Care <input type="checkbox"/> Hospice	<input type="checkbox"/> Inpatient Hospital Services <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Obstetrical Care -EDC: _____ <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: _____

PLEASE FAX THIS FORM TO (219) 392-7090

<p style="text-align: center;">APPROVAL</p> <p>Approved for: _____</p> <p>LOS/Type of Service: _____</p> <p>Auth #: _____</p> <p>Signature of Reviewer: _____</p> <p>Date: _____</p>	<p style="text-align: center;">NON-APPROVAL</p> <p>Reason: _____</p> <p>_____</p> <p>Signature of Reviewer: _____</p> <p>Date: _____</p>
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By accepting this referral an seeking payment from the Network, you indicate that you have read and agree to the Indiana Medicaid fee schedule. Under this contractual agreement, you will be entitled to no additional fees beyond those allowed by the Indiana Medicaid fee schedule. Any attempt to collect additional fees from the Network or from another party which offsets those fees against the Network may be regarded as a breach of this agreement.

Claims Address: MDwise St. Catherine Network P. O. Box 603 Brownsburg, IN 46112 (888) 504-5556 ext. 265
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Signature _____