

**MDwise St. Vincent
PRIOR AUTHORIZATION REQUEST**

IF NOT COMPLETED IN FULL, REQUEST WILL BE RETURNED

MDwise St. Vincent
9045 River Road Suite 250
Indianapolis, Indiana 46240

PHONE: (317) 569-2028 (877) 247-0820
FAX: (317) 570-6818 (800) 747-3693

PERSON SUBMITTING REQUEST: _____

PHONE#: _____

DATE: _____

PATIENT NAME: _____

RID#: _____ DOB: _____

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PMP: _____

SCP: _____ SPECIALTY: _____

DIAGNOSIS: _____ ICD-9 CODE(S): _____

PROCEDURE: _____ CPT-4 CODE(S): _____

CONSULT ONLY: CONSULT & TREAT: INPATIENT: OUTPATIENT:

DATE OF SERVICE (if available): _____ TREATMENT PLAN/MEDICAL INFORMATION: _____

IF REQUESTING APPROVAL FOR NON-PARTICIPATING PROVIDER, INDICATE WHY PARTICIPATING PROVIDER CANNOT PROVIDE SERVICE: _____

IS INJURY THE RESULT OF: MOTOR VEHICLE ACCIDENT: WORK RELATED:

NAME OF ADDITIONAL INSURANCE: _____

REFERRAL TYPE: SELF REFERRED: REFERRED BY PMP:

PLEASE DO NOT WRITE BELOW THIS LINE. FOR MDWISE ST. VINCENT ONLY.

AUTHORIZATION#: _____ DATE: _____

(APPROVAL FOR CONSULT & TX. IS VALID FOR 30 DAYS)

RN SUBMITTING AUTH.: _____ EXT.: _____ DATE SUBMITTED: _____

MED. DIRECTOR'S DECISION:

____ APPROVED
____ DENIED
____ PENDING FOR FURTHER RESEARCH

REASON FOR DENIAL:

____ NOT MEDICALLY NECESSARY
____ NOT A COVERED BENEFIT
____ SERVICES AVAILABLE IN NETWORK
____ PRESENTING SYMPTOMS DO NOT SUPPORT A PRUDENT LAYPERSON REASON TO SEEK EMERGENCY CARE
____ OTHER, SEE ATTACHED DOCUMENTATION
____ NO AUTHORIZATION RECEIVED FROM PMP

REASON FOR APPROVAL:

____ MEDICALLY NECESSARY
____ COVERED BENEFIT
____ CONTINUITY OF CARE
____ REFERRED BY PMP

MEDICAL DIRECTOR'S COMMENTS/SIGNATURE: _____

You Will Receive A Response To Your Fax Within 48 Hours Once All Medical Documentation Is Received