Date:

MDwise/Community Healthcare System

Referral / Pre-Authorization Form

Phone (219) 392-7072 Fax (219) 392-7090

Patient Name: ________________________ **Date of Birth:** ____________ **Patient ID #:** _______________

PRIMARY MEDICAL PHYSICIAN:	REFERRED TO:
	☐ **In-Network** ☐ **Out of Network**
Name: ______________________________	**Name:** ______________________________
	Specialty: ______________________________
Address: ______________________________	**Address:** ______________________________
______________________________	______________________________
Phone: ______________________________	**Phone:** ______________________________
Fax: ______________________________	**Fax:** ______________________________
Signature: ______________________________	

Diagnosis: ______________________________ DxCode: ____________________ Procedure Code: __________________

Reason for Referral/Symptoms/Previous Treatment: ____

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SERVICE REQUESTED

This referral does not authorize benefits for non-covered services.

☐ Chemotherapy/Radiation Oncology	☐ Inpatient Hospital Services	☐ Rehabilitation Services (PT/OT/ST)
☐ Dialysis	☐ Mental Health Services	☐ SNF Confinement
☐ DME (over $250)	☐ Obstetrical Care -EDC: _________________	☐ Same Day Surgery
☐ Orthotics/Prosthetics	☐ Physician Office # Visits: _____	☐ Transplant Work-up
☐ Home Health Care	☐ Plastic /Reconstructive Services	☐ Other: ___________________ ___________________
☐ Hospice		

SERVICES AUTHORIZED FROM: ____________________TO: ____________________

PLEASE FAX THIS FORM TO (219) 392-7090

APPROVAL	NON-APPROVAL
Approved for: ________________________________	Reason: ________________________________
________________________________	________________________________
LOS/Type of Service: ________________________	________________________________
Auth #: ________________________________	________________________________
Signature of Reviewer: ______________________	Signature of Reviewer: ______________________
Date: ________________________________	Date: ________________________________

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 Family Planning Claims
P.O. Box 68970
Indianapolis, IN 46268-0970
(800) 927-7927

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Signature

Revised 12-28-05