Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the plan in which the member is enrolled.

Traditional	☐ **ADVANTAGE Traditional**	**P: 800-269-5720**	**F: 800-689-2759**
Hoosier Healthwise	☐ **Anthem Hoosier Healthwise**	**P: 866-408-7187**	**F: 866-406-2803**
	☐ **Anthem HHW – SFHN**	**P: 800-291-4140**	**F: 800-747-3693**
	☐ **MDwise Hoosier Healthwise**	**See www.mdwise.org**	
	☐ **MHS Hoosier Healthwise**	**P: 877-647-4848**	**F: 866-912-4245**
Healthy Indiana Plan	☐ **Anthem HIP**	**P: 866-398-1922**	**F: 866-406-2803**
	☐ **MDwise HIP**	**See www.mdwise.org**	
	☐ **MHS HIP**	**P: 877-647-4848**	**F: 866-912-4245**
Hoosier Care Connect	☐ **Anthem**	**P: 866-408-6132**	**F: 866-408-7087**
	☐ **MDwise**	**P: 844-293-6309**	**F: 844-407-6454**
	☐ **MHS**	**P: 877-647-4848**	**F: 800-912-4245**
Care Select	☐ **ADVANTAGE and MDwise**	**P: 800-784-3981**	**F: 800-689-2759**

Please complete all appropriate fields.

Patient Information
Medicaid ID/RID#:
DOB:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI#:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		**Dx2**		**Dx3**	

Requesting Provider Information
Requesting Provider NPI#:
Tax ID#:
Service Location Code:
Provider Name:

Rendering Provider Information
Rendering Provider NPI#:
Tax ID#:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:

☐**DME**
- ☐***Purchased***
- ☐***Rented***

☐**Home Health**
☐**Hospice**
☐**Inpatient**
☐**Observation**
☐**Office Visit**
☐**Occupational Therapy**
☐**Outpatient**
☐**Physical Therapy**
☐**Speech Therapy**
☐**Transportation**
☐**Other**

Dates of Service Start	Stop	**Procedure/ Service Codes**	**Modifier(s)**		**Requested Service**	**Taxonomy**	**POS**	**Units**	**Dollars**

Notes:

PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.

Signature of Qualified Practitioner _____ Date: _____