Indiana Health Coverage Programs
Prior Authorization Request Form

Check the box of the entity that must authorize the service (for managed care, check the member's plan unless the service is delivered as fee-for-service).

Fee-for-Service	☐ **Cooperative Managed Care Services (CMCS)**	**P: 800-269-5720**	**F: 800-689-2759**
Hoosier Healthwise	☐ **Anthem Hoosier Healthwise**	**P: 866-408-7187**	**F: 866-406-2803**
	☐ **Anthem Hoosier Healthwise – SFHN**	**P: 800-291-4140**	**F: 800-747-3693**
	☐ **CareSource Hoosier Healthwise**	**P: 844-607-2831**	**F: 844-432-8924**
	☐ **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**
	☐ **CareSource HIP**	**P: 844-607-2831**	**F: 844-432-8924**
	☐ **MDwise HIP**	**See www.mdwise.org**	
	☐ **MHS HIP**	**P: 877-647-4848**	**F: 866-912-4245**
Hoosier Care Connect	☐ **Anthem Hoosier Care Connect**	**P: 866-408-7187**	**F: 866-406-2803**
	☐ **MDwise Hoosier Care Connect**	**P: 844-293-6309**	**F: 844-407-6454**
	☐ **MHS Hoosier Care Connect**	**P: 877-647-4848**	**F: 866-912-4245**

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**	**Modifiers**		**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: _____