Indiana Health Coverage Programs
Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Check the radio button of the entity that must authorize the service based on the member's enrollment/ benefits.

Fee-for-Service	○ Gainwell Technologies	P: 800-457-4584, option 7	F: 800-689-2759
Hoosier Healthwise	○ Anthem Hoosier Healthwise	P: 866-408-6132	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	○ CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	○ MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	○ MHS Hoosier Healthwise	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Healthy Indiana Plan (HIP)	○ Anthem HIP	P: 844-533-1995	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	○ CareSource HIP	P: 844-607-2831	F: 844-432-8924
	○ MDwise HIP	P: 888-961-3100	F: Inpatient 866-613-1631 Outpatient: 866-613-1642
	○ MHS HIP	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Hoosier Care Connect	○ Anthem Hoosier Care Connect	P: 844-284-1798	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	○ MHS Hoosier Care Connect	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
	○ UnitedHealthcare	P: 877-610-9785	F: Inpatient and Outpatient: 844-897-6514

Please complete all appropriate fields.

Patient Information
IHCP Member ID:
Date of Birth:
Patient Name:
Address:
City/State/ZIP Code:
Patient/Guardian Phone:
PMP Name:
PMP NPI:
PMP Phone:

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

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

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
Provider Address:

Rendering Provider Information
Rendering Provider NPI:
TIN:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

Please check the requested assignment category below:

☐ Inpatient ☐ Residential

Dates of Service Start	Stop	Procedure/ Service Codes	Modifiers		Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Notes:

Mandatory Additional Documentation Checklist

☐ *Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission*	☐ Intake assessment	☐ Clinical assessment	☐ Psychosocial assessment	☐ Treatment goals and plans

Signature of Qualified Practitioner _____ Date: _____

See the *IHCP Quick Reference Guide* for information about where to mail this form.