MDwise
A McLaren Company

Prior Authorization Appeal Form

Date: _____

Facility/Provider Name: _____

Telephone Number: _____ Ext.: _____ Fax: _____

Member Name: _____ Date of Birth: _____

Member ID #: _____ Authorization #: _____

Date of Service (*Start*): _____ Date of Service (*End*): _____

MDwise Program:
(please select one)

☐ Hoosier Healthwise ☐ HIP

Please note: Prior Authorization appeals must be received within 60 (sixty) calendar days of the denial

Authorization Appeal Reason:

Please include a summary of your appeal reason in the box above. If you would like to include additional clinical documentation, please attach along with this form prior to sending.

Form Completed By *(please print)*:_____ Date:_____

If you are unable to submit electronically, please mail this form and documentation to the following address:

MDwise
Attention: Medical Management/Appeals
PO Box 44236
Indianapolis, IN 46244-0236

Please provide your correspondence address:

_____

_____

_____