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**
	☐ **MDwise Hoosier Healthwise**	**See www.mdwise.org**	
	☐ **MHS Hoosier Healthwise**	**P: 877-647-4848**	**F: 866-912-4245**
Healthy Indiana Plan	☐ **Anthem HIP**	**P: 866-408-7187**	**F: 866-406-2803**
	☐ **MDwise HIP**	**See www.mdwise.org**	
	☐ **MHS HIP**	**P: 877-647-4848**	**F: 866-912-4245**
Care Select	☐ **Advantage Care Select**	**P: 800-784-3981**	**F: 800-689-2759**
	☐ **MDwise Care Select**	**P: 866-440-2449**	**F: 877-822-7186**

Please complete all appropriate fields.

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

Medical Diagnosis (Use of ICD-9 Diagnostic Code is Required)					
Dx1		Dx2		Dx3	

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

Rendering Provider Information
Ordering Physician NPI#:
Tax ID #:
Name:
Address:
City/State/Zip:
Phone:
Fax:

Preparer's Information:
Name:
Phone:
Fax:

Please check 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	Dates of Service 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:_____