

Indiana Health Coverage Programs Prior Authorization Request Form

Select the radio button of the entity that must authorize the service.
(For managed care, check the member's plan, unless the service is carved out [delivered as fee-for-service].)

Fee-for-Service	Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-6132	F: 866-406-2803
	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: 866-912-4245
Healthy Indiana Plan (HIP)	Anthem HIP	P: 844-533-1995	F: 866-406-2803
	CareSource HIP	P: 844-607-2831	F: 844-432-8924
	MDwise HIP	P: 888-961-3100	F: 866-613-1642
	MHS HIP	P: 877-647-4848	F: 866-912-4245
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 844-284-1798	F: 866-406-2803
	MHS Hoosier Care Connect	P: 877-647-4848	F: 866-912-4245
	UnitedHealthcare	P: 877-610-9785	F: 844-897-6514
Indiana PathWays for Aging	Anthem PathWays	P: 844-284-1798	F: 877-410-0623
	Humana PathWays	P: 866-274-5888	F: 502-324-6376
	UnitedHealthcare PathWays	P: 877-610-9785	F: 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	

Please check the requested assignment category below:

DME	Inpatient	Physical Therapy
Purchased	Observation	Speech Therapy
Rented	Office Visit	Transportation
Home Health	Occupational Therapy	Other
Hospice	Outpatient	

Requesting Provider Information	
Requesting Provider NPI/Provider ID:	
Taxonomy:	
Taxpayer Identification Number (TIN):	
Provider Name:	
Provider Address:	
Rendering Provider Information	
Rendering Provider NPI/Provider ID:	
TIN:	
Name:	
Address:	
City/State/ZIP Code:	
Phone:	
Fax:	
Preparer's Information	
Name:	
Phone:	
Fax:	

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

Notes:

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

Signature of Qualified Practitioner _____ Date: _____

See the [IHCP Quick Reference Guide](#) for information about where to mail this form.