

# 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].)

<b>Fee-for-Service</b>	<input type="radio"/> Acentra Health	<b>P: 866-725-9991</b>	<b>F: 800-261-2774</b>
<b>Hoosier Healthwise</b>	<input type="radio"/> Anthem Hoosier Healthwise	<b>P: 866-408-6132</b>	<b>F: 866-406-2803</b>
	<input type="radio"/> CareSource Hoosier Healthwise	<b>P: 844-607-2831</b>	<b>F: 844-432-8924</b>
	<input type="radio"/> MDwise Hoosier Healthwise	<b>P: 888-961-3100</b>	<b>F: 888-465-5581</b>
	<input type="radio"/> MHS Hoosier Healthwise	<b>P: 877-647-4848</b>	<b>F: 866-912-4245</b>
<b>Healthy Indiana Plan (HIP)</b>	<input type="radio"/> Anthem HIP	<b>P: 844-533-1995</b>	<b>F: 866-406-2803</b>
	<input type="radio"/> CareSource HIP	<b>P: 844-607-2831</b>	<b>F: 844-432-8924</b>
	<input type="radio"/> MDwise HIP	<b>P: 888-961-3100</b>	<b>F: 866-613-1642</b>
	<input type="radio"/> MHS HIP	<b>P: 877-647-4848</b>	<b>F: 866-912-4245</b>
<b>Hoosier Care Connect</b>	<input type="radio"/> Anthem Hoosier Care Connect	<b>P: 844-284-1798</b>	<b>F: 866-406-2803</b>
	<input type="radio"/> MHS Hoosier Care Connect	<b>P: 877-647-4848</b>	<b>F: 866-912-4245</b>
	<input type="radio"/> UnitedHealthcare	<b>P: 877-610-9785</b>	<b>F: 844-897-6514</b>
<b>Indiana PathWays for Aging</b>	<input type="radio"/> Anthem PathWays	<b>P: 844-284-1798</b>	<b>F: 866-406-2803</b>
	<input type="radio"/> Humana PathWays	<b>P: 866-274-5888</b>	<b>F: 502-324-6376</b>
	<input type="radio"/> UnitedHealthcare PathWays	<b>P: 877-610-9785</b>	<b>F: 844-897-6514</b>

**Please complete all appropriate fields.**

Patient Information			
<b>IHCP Member ID:</b>			
<b>Date of Birth:</b>			
<b>Patient Name:</b>			
<b>Address:</b>			
<b>City/State/ZIP Code:</b>			
<b>Patient/Guardian Phone:</b>			
<b>PMP Name:</b>			
<b>PMP NPI:</b>			
<b>PMP Phone:</b>			
Ordering, Prescribing or Referring (OPR) Provider Information			
<b>OPR Provider NPI:</b>			
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)			
<b>Dx1</b>	<b>Dx2</b>	<b>Dx3</b>	

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

**Please check the requested assignment category below:**

<input type="checkbox"/> DME	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Purchased	<input type="checkbox"/> Observation	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Rented	<input type="checkbox"/> Office Visit	<input type="checkbox"/> Transportation
<input type="checkbox"/> Home Health	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other
<input type="checkbox"/> Hospice	<input type="checkbox"/> Outpatient	

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.