

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
	☐ 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
	☐ 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: 866-406-2803
	☐ 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	
Assignment Category					
Please check the requested assignment category below:					
☐ DME - Purchased	☐ Observation	☐ Speech Therapy			
☐ DME - Rented	☐ Office Visit	☐ Transportation			
☐ Home Health	☐ Occupational Therapy	☐ Other			
☐ Hospice	☐ Outpatient				
☐ Inpatient	☐ Physical Therapy				

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

Start Date	Stop Date	Procedure/Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Service Description	Taxonomy	Place of Service (POS) Code	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.