Indiana Health Coverage Programs Prior Authorization Request Form
Instructions
(universal prior authorization form)

Note: These instructions should also be followed when completing the Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form.

Field	Description
Check 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].)	Select the appropriate radio button. • If the service requested would be covered under a managed care program, select the radio button for the member's assigned managed care entity (MCE). • If the service requested would be covered as fee-for-service (FFS) – including services carved out of managed care – select the radio button for the FFS authorization entity.
Patient Information: • IHCP Member ID (RID) • Date of Birth • Patient Name • Address • City/State/ZIP Code • Patient/Guardian Phone • PMP Name • PMP NPI • PMP Phone	Enter the information requested for the member who is to receive the requested service. **Required.** Enter the information requested for the member's primary medical provider (PMP). **Required, if applicable.**
Requesting Provider Information: • Requesting Provider NPI/ Provider ID • Taxonomy • Tax ID • Provider Name	Enter the information requested for each field. **Required.** Requesting medical providers should enter their National Provider Identifier (NPI). Atypical providers should enter their IHCP-issued Provider ID. The requesting provider NPI/Provider ID must be the billing NPI/ Provider ID used by the provider or entity requesting the authorization: • For a group/corporate entity, the requesting provider NPI/Provider ID is different from the rendering provider NPI/Provider ID. • For a sole proprietor, the requesting provider NPI/Provider ID and the rendering provider NPI/Provider ID will be the same. • For a dual-status provider, the requesting provider NPI/Provider ID and the rendering provider NPI/Provider ID may or may not be the same. A valid NPI or Provider ID is required. If the requesting provider is not enrolled in the IHCP, the PA request will not be entered and the PA contractor will notify the requesting provider by telephone. The provider's copy of the *Indiana Medicaid Prior Authorization Notification* (PA notification letter) is sent to the mail-to address on file for the requesting provider's NPI and Provider ID combination.
Rendering Provider Information: • Rendering Provider NPI/Provider ID • Tax ID • Name • Address • City/State/ZIP Code • Phone • Fax	Enter the information requested for each field, if the rendering provider is known at the time the request is completed. (The rendering provider is the physician or other IHCP-enrolled practitioner who will be delivering the service to the member.) Enter the rendering provider's NPI or, for atypical providers that do not have an NPI, enter the rendering provider's IHCP Provider ID.

Field	Description
Ordering, Prescribing, or Referring (OPR) Provider Information: • OPR Physician NPI	Enter the NPI of the OPR provider. (The OPR provider is the practitioner that ordered, prescribed, or referred the member for the requested service.)
Preparer's Information: • Name • Phone • Fax	Enter the requested information about the person preparing the PA request.
Medical Diagnosis • Dx1 • Dx2 • Dx3	Enter the primary, secondary, and tertiary International Classification of Diseases (ICD) diagnosis codes.
Assignment Category	Check the assignment category for the service you are requesting.
Dates of Service, Start	Enter the requested start date of service. (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Enter the requested stop date of service.
Procedure/Service Codes	Enter the requested service codes, such as Current Procedural Terminology (CPT®[1]), Healthcare Common Procedure Coding System (HCPCS), revenue code, National Drug Code (NDC), and so forth.
Modifiers	Enter any applicable service code modifiers.
Service Description	Enter a short description (or include an attachment) of the requested services and like services provided by other payers.
Taxonomy	Enter any applicable taxonomy codes.
Place of Service (POS)	Enter the requested place of service.
Units	Enter the requested number of units. Units are equal to days, months, or items, whichever is applicable.
Dollars	Enter the estimated or known IHCP cost of the service. **Required for home health services and durable medical equipment (DME) requests.**
Notes	Enter clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan-of-treatment dates. Your request MUST include medical documentation to be reviewed for medical necessity.
Mandatory Additional Documentation Checklist	*Note: This field is only on the Residential/Inpatient SUD Treatment PA Request Form.* Check each box to indicate that the required documentation is included with request. **Required.**
Signature of Qualified Practitioner Date	Authorized provider, as listed in the *Provider Types Allowed to Submit PA Requests* section of the *Prior Authorization* provider reference module and *405 IAC 5-3-10*, must sign and date the form. Signature stamps can be used. **Required.**

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