

Indiana Health Coverage Programs Prior Authorization System Update Request Form

Date: _____ Requesting provider NPI: _____
Mail-to Provider ID: _____
Service location: _____
Provider name: _____
Contact person: _____
Telephone: _____

Member name: _____

Member ID (RID): _____

Prior authorization #: _____

Service code (CPT/modifier/taxonomy, HCPCS, ICD, and so forth):

Summary of requested actions:

Changes prompting the system update request:

Prior Authorization Department use only

Reviewer: _____

Date system: _____

Update: _____

Decision and comments:

See the [IHCP Provider Quick Reference](#) at in.gov/medicaid/providers for mailing address or fax number. A copy of the decision will be provided to the requesting provider and to the member. **NOTE:** Prior authorization system update requests can also be submitted via the IHCP [Provider Healthcare Portal](#).