Indiana Health Coverage Programs
Prior Authorization Request Form

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].)

Fee-for-Service	○ **Gainwell Technologies**	**P: 1-800-457-4584, option 7**	**F: 1-800-689-2759**
Hoosier Healthwise	○ **Anthem Hoosier Healthwise**	**P: 1-866-408-6132**	**F: 1-866-406-2803**
	○ **CareSource Hoosier Healthwise**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise Hoosier Healthwise**	**P: 1-888-961-3100**	**F: 1-888-465-5581**
	○ **MHS Hoosier Healthwise**	**P: 1-877-647-4848**	**F: 1-866-912-4245**
Healthy Indiana Plan (HIP)	○ **Anthem HIP**	**P: 1-844-533-1995**	**F: 1-866-406-2803**
	○ **CareSource HIP**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise HIP**	**P: 1-888-961-3100**	**F: 1-866-613-1642**
	○ **MHS HIP**	**P: 1-877-647-4848**	**F: 1-866-912-4245**
Hoosier Care Connect	○ **Anthem Hoosier Care Connect**	**P: 1-844-284-1798**	**F: 1-866-406-2803**
	○ **MHS Hoosier Care Connect**	**P: 1-877-647-4848**	**F: 1-866-912-4245**
	○ **UnitedHealthcare**	**P: 1-877-610-9785**	**F: 1-844-897-6514**

Please complete all appropriate fields.

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:
Ordering, Prescribing, or Referring (OPR) Provider Information
OPR Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		**Dx2**		**Dx3**	

Please check the requested assignment category below:

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

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Taxpayer Identification Number (TIN):
Provider Name:
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.