Return PA form to: MedImpact at: (Fax 858-790-7100)

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	○ **Cooperative Managed Care Services (CMCS)**	**P: 1-800-269-5720**	**F: 1-800-689-2759**
Hoosier Healthwise	○ **Anthem Hoosier Healthwise**	**P: 1-866-408-6132**	**F: 1-866-406-2803**
	○ **Anthem Hoosier Healthwise – SFHN**	**P: 1-800-291-4140**	**F: 1-800-747-3693**
	○ **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**

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**	

Requesting Provider Information
Requesting Provider NPI/Provider ID:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information
Rendering Provider NPI/Provider ID:
Tax ID:
Name:
Address:
City/State/ZIP Code:
Phone:
Fax:

Preparer's Information
Name:
Phone:
Fax:

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

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: ______________