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	◯ **Kepro**	**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**
	◯ **MDwise Hoosier Healthwise**	**P: 888-961-3100**	**F: 888-465-5581**
	◯ **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**
	◯ **MDwise HIP**	**P: 888-961-3100**	**F: 866-613-1642**
	◯ **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**

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**	

Requesting Provider Information
Requesting Provider NPI/Provider ID: 1184602518
Taxonomy: 100013680A
Taxpayer Identification Number (TIN): 341174227
Provider Name: Prentke Romich Co
Provider Address: 1022 Heyl Rd Wooster, OH 44691
Rendering Provider Information
Rendering Provider NPI/Provider ID: 1184602518
TIN: 341174227
Name: Prentke Romich Company
Address: 1022 Heyl Rd
City/State/ZIP Code: Wooster, OH 44691
Phone: 330-262-1984 x 1281
Fax: 330-202-5854
Preparer's Information
Name: Lucy Enderby
Phone: 330-262-1984 x 1281
Fax: 330-202-5854

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**
		E2510	NU			100013680A	Home		

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.