



## Indiana University Health Medical Management Authorization Request Form

Forward completed form via FAX to IUHMM at (317) 962-6219

<p><b>REQUESTING PHYSICIAN INFORMATION</b></p> <p>Ordering MD: _____</p> <p>**TAX ID: _____</p> <p>Address: _____</p> <p>Phone: _____ Fax: _____</p> <p>Contact: _____</p>	<p><b>REQUESTING VENDOR INFORMATION</b></p> <p>Vendor: _____</p> <p>**TAX ID: _____</p> <p>Address: _____</p> <p>Phone: _____ Fax: _____</p> <p>Contact: _____</p>
<p><b>MEMBER INFORMATION</b></p> <p>Name: _____</p> <p>ID#: _____</p> <p>DOB: ____/____/____</p> <p>SS#: ____/____/____</p> <p>Phone: _____</p>	<p style="text-align: center; color: red;"><b>*****IUHMM USE ONLY*****</b></p> <p><b>AUTHORIZATION NUMBER</b> _____</p> <p><input type="checkbox"/> Services <b>APPROVED</b> As Requested</p> <p><input type="checkbox"/> Request <b>MODIFIED</b> (see below for detail)</p> <p><input type="checkbox"/> Request <b>DENIED</b>, Letter To Follow</p> <p><b>Modifications</b></p> <p><b>Made:</b> _____</p> <p><b>IUHMM Staff:</b> _____</p> <p><b>Date:</b> _____</p>

Date of Service	CPT or HCPC Code	Requested Service	Place of Service INP OP OBS	Units	Diagnosis / ICD9 Code

**CLINICAL SUMMARY** (Form will be *rejected* if CLINICAL SUMMARY is NOT completed). (Send attachments, if needed).

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\* You must save this document for your signature to be applied.

**SIGNATURE OF REQUESTING MD:** \_\_\_\_\_ **DATE:** \_\_\_\_\_