Prior Authorization Request

Vendor/Organization:______________________ Tax ID#:______________ NPI#:______________

Address:______________________ Phone#:______________________

Contact Name:______________________ Fax#:______________________

Ordering MD Name:______________________ MD NPI#:______________________

Date Submitted:______________________ MD Tax ID (needed if out-of-network):______________

Patient Information

First Name:______________ Last Name:______________ Member ID#:______________

Address: ______________________ Phone#:______________ DOB:______________

Plan Type: ☐ Commercial ☐ Medicare Advantage ☐ Individual & Family Plans

Clinical Information

Service Dates (from-through):	CPT or HCPC Code(s):	Requested Service:	Place of Service + INP, OP, OBS:	Units:	Diagnosis/ ICD10 Code(s):

Clinical Summary/Comments (Your comments must include documentation explaining medical necessity of request, such as lab results & dates, symptoms, etc… Attach documents if necessary): ______________________

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Is this service out-of-network? ☐ Yes ☐ No

If "yes," please explain why the patient is being sent out-of-network:______________________

IU Health Medical Management Only Fields

Authorization#:____

☐ Services Approved as Requested ☐ Request Modified ☐ Request Denied, Letter to Follow

Modifications Made: ____

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IUHMM Staff Signature: ______________________ Date:______________

Health Plans

Print your completed form and fax it to Population Health Medical Management at 317.962.6219, or call 317.962.2378 if you have questions about prior authorization and referrals. Medical Management is open Monday through Friday, 8:30 a.m.-4:30 p.m. For urgent requests on weekends/ holidays call 317.962.2378. Please note: Missing information could result in a denial of your request. Prior authorization resources can be found on www.iuhealthplans.org/provider/prior-authorization.