Indiana University Health

Indiana University Health Medical Management Authorization Request Form

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

REQUESTING PHYSICIAN INFORMATION
Ordering MD: _____
****TAX ID**: _____
Address: _____
Phone: _____ Fax: _____
Contact: _____

REQUESTING VENDOR INFORMATION
Vendor: _____
****TAX ID**: _____
Address: _____
Phone: _____ Fax: _____
Contact: _____

MEMBER INFORMATION
Name: _____
ID#: _____
DOB: _____/_____/_____
SS#: _____/_____/_____
Phone: _____

********IUHMM USE ONLY********
AUTHORIZATION NUMBER_____
□ Services **APPROVED** As Requested
□ Request **MODIFIED** (see below for detail)
□ Request **DENIED**, Letter To Follow
Modifications Made:_____
IUHMM Staff:_____
Date:_____

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).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

SIGNATURE OF REQUESTING MD: _____ **DATE**: _____