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): _____

_____

_____

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: _____

_____

_____

IUHMM Staff Signature: _____ Date:_____

IU HEALTH 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.