Prior Authorization form

This form may be typed at your convenience.
☐ **Medicare Advantage** ☐ **Commercial**

Medicare Advantage and Commercial Plans may have different prior authorization requirements. Check the appropriate prior authorization list at iuhealthplans.org before submitting your request. Complete the appropriate fields and fax the form to Medical Management at 317.962.6219 or call 317.962.2378 if you have questions about prior authorization and referrals. Prior authorizations may be submitted 24 hours a day/seven days a week. Missing information could result in a denial of your request.

Requesting provider (Practitioner, provider or facility ordering or referring services)

Requesting provider:	NPI #:	Tax ID #:	
Contact person's name:	Contact person's email:		
Phone #:	Fax #:		
Address:	City:	State:	ZIP:

Type of request

☐ Urgent (significant impact to health of patient) **or** ☐ Non-urgent pre-service standard **or** ☐ Post-service

Patient information

First name:	Last name:	Date of birth:
Member ID #*:	Work-related injury? ☐ Yes ☐ No	Motor vehicle accident-related injury? ☐ Yes ☐ No
Home phone #:	Cell phone #:	
Address:	City:	State: ZIP:

**11-digit member ID includes letters and numbers*

Servicing provider (Practitioner, provider or facility performing services on patient)

Servicing provider:	NPI #:	Tax ID #:	
Contact person's name:	Contact person's email:		
Phone #:	Fax #:		
Address:	City:	State:	ZIP:
Is the provider in network? ☐ Yes ☐ No			

Type of request (Choose applicable services)

☐ Applied Behavioral Analysis*
☐ Behavioral Health – Inpatient
☐ Behavioral Health – Outpatient
☐ Durable Medical Equipment Purchase
☐ Durable Medical Equipment Rental
☐ Home Health
☐ Hospice
☐ Medical/Surgical – Inpatient
☐ Medical/Surgical – Outpatient
☐ Oral Surgery
☐ Private Duty Nursing *(for Commercial Only)*
☐ Transition of Care
☐ Transplant Admission
☐ Transplant Evaluation
☐ Transportation Air
☐ Transportation Land ALS
☐ Transportation Land BLS
☐ Other: ____________________

**Please submit Applied Behavioral Analysis Treatment Report with this PA form request.*

Clinical information (Request **must** include medical documentation to support medical necessity of the request)

Any supporting documents included? ☐ Yes ☐ No	Number of pages:
Primary ICD-10 code:	Description:

Dates of service		Procedure/ Service codes	Diagnosis code	Requested service	Requested units/visits
Start	Stop				

Should additional procedure or service codes be requested, please complete page 2 of this form and submit it with your request.

Health Plans

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Prior Authorization form – additional codes only

This form may be typed at your convenience.
☐ **Medicare Advantage** ☐ **Commercial**

Complete this page only if additional procedure or service codes were requested. Submit this form with page 1 of your request.

Patient information

First name:	Last name:
Date of birth:	Member ID #*:

**11-digit member ID includes letters and numbers*

Dates of service		Procedure/ Service codes	Diagnosis code	Requested service	Requested units/visits
Start	Stop				

Health Plans

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