



INDIANA PRIOR REVIEW AND AUTHORIZATION REQUEST

(# REQUIRED IF MEDICAID PROVIDER) PMP ()

Requesting Provider # _____ Phone: _____

Mail to Provider: _____

Service Location: _____

Name _____

Address _____

City/State/ZIP _____

Rendering Provider # _____ Phone _____

Name _____

Address _____

City/State/ZIP _____

INTERNAL USE ONLY

(1) HOME HEALTH	(8) AUDIOLOGY	(14) RESPIRATORY THERAPY (RT)
(2-3) HOSP., OUT PT	(9) SPEECH	(15) DENTAL SERVICES
(4) PHYSICIAN	(10) MENTAL HEALTH SERVICES	(16) OPTOMETRIC SERVICES (OD)
(5) REHAB.	(11) DURABLE MEDICAL EQUIPMENT	(17) PODIATRY SERVICES
(6) TRANSPLANT	(12) OCCUPATIONAL THERAPY (OT)	(18) CHIROPRACTIC SERVICES
(7) TRANSPORTATION	(13) PHYSICAL THERAPY (PT)	(19) PHARMACEUTICAL SERVICES

MCO () 590 () FFS () MS () CS ()

RID No. _____ DOB _____

Name _____

Address _____

City/State/ZIP _____

MEDICAL DIAGNOSIS: (USE OF ICD-9-CM DIAGNOSTIC CODE REQUIRED)

Primary _____
Secondary _____

Is this a request for continuing service? Yes No (No gap in certification)

Will DME be: Purchased: Rented: Repaired: Length of time DME required: _____

Has service or medical supply been previously provided? Yes Date _____ No

WARNING: ANY AUTHORIZATION IS VALID ONLY IF THE MEMBER IS ELIGIBLE ON THE DATE SERVICE WAS PROVIDED.

DATES OF SERVICE		SERVICE CODE (REQUIRE D)	MODIFIER (S)	REQUESTED SERVICE	TAXONOMY	POS	UNITS	DOLLARS
START MMDDCCYY	STOP MMDDCCYY							

Clinical Summary: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Home Health, and Transportation) must be attached.

Signature of Requesting Provider _____ Date _____
(original signature required) The above sections must be completed or the request will be rejected.
Date of Submission _____



INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Requesting Provider # _____ Phone: _____ RID NO: _____ DOB: _____
 Mail to Provider ID: _____ Service Location: _____
 Name: _____ Name: _____
 Address: _____ Address: _____
 City/State/ZIP Code: _____ City/State/ZIP Code: _____

DATES OF SERVICE		SERVICE CODE REQUIRED	REQUESTED SERVICE	PLACE OF SERVICE	UNITS	DOLLARS
START MMDDCCYY	STOP MMDDCCYY					

Caseworker: _____ Phone: _____ MCO () 590 () FFS () MS () CS ()

Is Member Employed? YES NO Circumstances (Place/Type)::
 Is Member in Job Training? YES NO Type of Job Training:

Dental Treatment Plan

1. Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Periodontics – Evaluate the periodontal condition

3. Partial dentures (use chart to right to indicate teeth involved)

A. Date or dates of extractions of missing teeth.

B. Which teeth (use tooth number) are to be extracted?

C. Which teeth (use tooth number) are to be replaced?

D. Brief description of materials and design of partial.

E. Is member wearing partials now? YES NO Age of present partials

4. Dentures (check one or both): Full upper denture Full lower denture

A. How long edentulous

B. Is member wearing dentures now? YES NO Age of present dentures

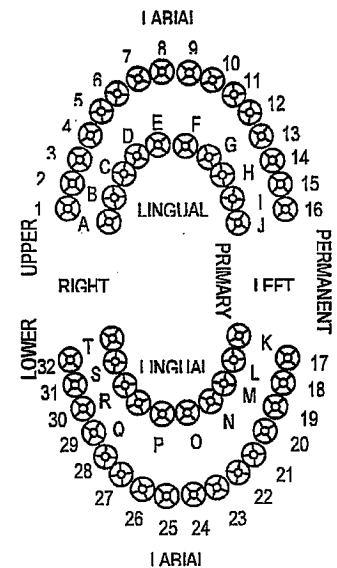
5. Describe treatment if different from above:

6. Is the member on parenteral/enteral nutritional supplements? YES NO

If YES, a plan of care to wean the member from the nutritional supplements must be attached. If the plan of care is not provided, dentures, partials, relines, and repairs will be denied.

Brief Dental/Medical History:

Does the Member have missing teeth? YES NO
 If YES please indicate missing teeth with an X.



Signature of Requesting Dentist _____ Date of Submission: _____

(original signature required) The above sections must be completed or the request will be rejected.

Mail to: <http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx>

Prior Authorization

System Update Request Form

Date: _____ Requesting Provider Number: _____
Mail to Provider ID: _____
Service Location: _____
Provider Name: _____
Contact Person: _____
Phone: _____

Member Name: _____
Member ID (RID): _____
Prior Authorization #: _____
Service Code (CPT/Modifier/Taxonomy, HCPCS, ICD-9-CM, and so forth):

Summary of requested action(s):

Change(s) prompting the system update request:

Prior Authorization Department Use Only

Reviewer: _____
Date System: _____
Update: _____

Decision and comments:

Mail to: <http://www.indianamedicaid.com/ihcp/ProviderServices/PAAttachmentAddresses.aspx>

A copy of the decision will be provided to the requesting provider and to the member.