

Indiana Health Coverage Programs Residential/Inpatient Substance Use Disorder Treatment Prior Authorization Request Form

Please use this form and its associated attachment if you have a 3.1 or 3.5 American Society of Addiction Medicine (ASAM) residential designation or are an inpatient psychiatric facility/hospital.

Select the radio button of the entity that must authorize the service based on the member's enrollment/benefits.

Fee-for-Service	Acentra Health	P: 866-725-9991	F: 800-261-2774
Hoosier Healthwise	Anthem Hoosier Healthwise	P: 866-408-6132	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	CareSource Hoosier Healthwise	P: 844-607-2831	F: 844-432-8924
	MDwise Hoosier Healthwise	P: 888-961-3100	F: 888-465-5581
	MHS Hoosier Healthwise	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Healthy Indiana Plan (HIP)	Anthem HIP	P: 844-533-1995	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	CareSource HIP	P: 844-607-2831	F: 844-432-8924
	MDwise HIP	P: 888-961-3100	F: Inpatient 866-613-1631 Outpatient: 866-613-1642
	MHS HIP	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
Hoosier Care Connect	Anthem Hoosier Care Connect	P: 844-284-1798	F: Inpatient: 877-434-7578 Outpatient: 866-877-5229
	MHS Hoosier Care Connect	P: 877-647-4848	F: Inpatient: 844-288-2591 Outpatient: 866-694-3649
	UnitedHealthcare	P: 877-610-9785	F: Inpatient and Outpatient: 844-897-6514

Please complete all appropriate fields.

Patient Information				
IHCP Member ID:				
Date of Birth:				
Patient Name:				
Address:				
City/State/ZIP Code:				
Patient/Guardian Phone:				
PMP Name:				
PMP NPI:				
PMP Phone:				
Ordering, Prescribing or Referring (OPR) Provider Information				
OPR Provider NPI:				
Medical Diagnosis (Use of ICD Diagnostic Code Is Required)				
Dx1		Dx2		Dx3

Requesting Provider Information	
Requesting Provider NPI:	
Taxonomy:	
Taxpayer Identification Number (TIN):	
Provider Name:	
Provider Address:	
Rendering Provider Information	
Rendering Provider NPI:	
TIN:	
Name:	
Address:	
City/State/ZIP Code:	
Phone:	
Fax:	
Preparer's Information	
Name:	
Phone:	
Fax:	

Please check the requested assignment category below:

Inpatient Residential

Dates of Service Start	Stop	Procedure/Service Codes	Modifiers	Service Description	Taxonomy	Place of Service (POS)	Units	Dollars

Notes:

Mandatory Additional Documentation Checklist

<i>Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission</i>	Intake assessment	Clinical assessment	Psychosocial assessment	Treatment goals and plans
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Signature of Qualified Practitioner _____ Date: _____

See the [IHCP Quick Reference Guide](#) for information about where to mail this form.