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.

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

Fee-for-Service	○ **Cooperative Managed Care Services (CMCS)**	**P: 1-800-269-5720**	**F: 1-800-689-2759**
Hoosier Healthwise	○ **Anthem Hoosier Healthwise**	**P: 1-866-408-6132**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **Anthem Hoosier Healthwise – SFHN**	**P: 1-800-291-4140**	**F: 1-800-747-3693**
	○ **CareSource Hoosier Healthwise**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise Hoosier Healthwise**	**P: 1-888-961-3100**	**F: 1-888-465-5581**
	○ **MHS Hoosier Healthwise**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**
Healthy Indiana Plan (HIP)	○ **Anthem HIP**	**P: 1-844-533-1995**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **CareSource HIP**	**P: 1-844-607-2831**	**F: 1-844-432-8924**
	○ **MDwise HIP**	**P: 1-888-961-3100**	**F: 1-866-613-1642**
	○ **MHS HIP**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**
Hoosier Care Connect	○ **Anthem Hoosier Care Connect**	**P: 1-844-284-1798**	**F: Inpatient: 1-877-434-7578 Outpatient: 1-866-877-5229**
	○ **MHS Hoosier Care Connect**	**P: 1-877-647-4848**	**F: Inpatient: 1-844-288-2591 Outpatient: 1-866-694-3649**

Please complete all appropriate fields.

Patient Information
IHCP Member ID (RID):
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 Physician NPI:

Medical Diagnosis (Use of ICD Diagnostic Code Is Required)					
Dx1		**Dx2**		**Dx3**	

Requesting Provider Information
Requesting Provider NPI:
Taxonomy:
Tax ID:
Provider Name:

Rendering Provider Information
Rendering Provider NPI:
Tax ID:
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

☐ *Initial Assessment Form for Substance Use Disorder (SUD) Treatment Admission*	☐ Intake assessment	☐ Clinical assessment	☐ Psychosocial assessment	☐ Treatment goals and plans

Signature of Qualified Practitioner _____ Date: _____