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.