Field	Description
Medicaid ID/RID# DOB Name/Address/City/State/ZIP/Phone PMP Name/NPI/Phone	Member information. Type the data requested for the member who is to receive the requested service. Type the data requested for the member's PMP.
Requesting Provider NPI # Tax ID# Service Location Code Provider Name	Requesting provider information. Type the data requested. The requesting or rendering provider's National Provider Identifier (NPI) is required if the provider is enrolled in the IHCP. If the requesting provider is not enrolled, type the practitioner's license number in the *Requesting Provider #* field. The provider's copy of the *Indiana Prior Review and Authorization Request Decision* form is sent to the address that corresponds to the provider's information entered in this field, if a separate mailing provider ID and service location are not identified on the form. If the requesting provider information does not have a valid service location, a PA decision letter is not generated. Therefore, providers must complete the mailing provider ID and service location fields to ensure that the PA decision letter is mailed to the correct address. If the mailing provider ID and service location fields are completed in conjunction with a requesting provider information that has a valid service location, the mailing provider ID and service location information is selected as the address – not the requesting provider number and service location information for mailing of the PA decision form.
Rendering Provider NPI# Tax ID# Name/Address/City/State/ZIP/Phone/Fax	Rendering provider's NPI number information. Type the data requested for the provider rendering the requested service, if known.
Preparer's Information	Type the name, phone number and fax number of the preparer
Medical Diagnosis Medical Diagnosis.	Type the primary, secondary, and tetiary *ICD-9-CM* diagnosis code(s).
Assignment Category	Please check which assignment category you are requesting service for.
Dates of Service, Start	Requested start date for the service (For continued services, the start date must be the day after the previous end date.)
Dates of Service, Stop	Requested stop date for the service.
Procedure/Service Code	Type the requested service code, such as Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), revenue, National Drug Code (NDC), and so forth.
Modifier(s)	Type any applicable service code modifiers.
Requested Service	Type a short narrative (or include attachment) of the requested service

	and like services provided by other payers.
Taxonomy	Type any applicable taxonomy codes.
POS	Type the requested place of service (POS).
Units	Type the number of units desired. Units are equal to days, months, or items, whichever is applicable.
Dollars	Type the estimated or known IHCP cost of the service. This is optional, except for home health services, DME equipment, and pharmacy requests.
Notes	Type clinical summary information. Additional pages can be attached, if necessary. A current plan of treatment and progress notes must be attached for the listed services. Requested dates of service should coincide with the plan of treatment dates.
Signature of Qualified Practitioner Date	Authorized provider, as listed in *Section 1* of this chapter and *405IAC 5-3-10*, must sign and date the form. Signature stamps can be used.