

SIHO REFERRAL NOTIFICATION / AUTHORIZATION REQUEST FORM

Phone: 1-800 553-6027

Fax: 1-812-378-7054

PATIENT ID: _____	DOB: _____
NAME, LAST: _____	FIRST: _____
M.I.: _____	

<p>Referring Physician :</p> <p>_____</p> <p style="text-align: center;">Name of Referring Physician</p> <p>_____</p> <p style="text-align: center;">Address</p> <p>_____</p> <p style="text-align: center;">City/State/Zip</p> <p>_____</p> <p style="text-align: center;">Tax ID number/NPI number</p> <p>_____</p> <p>Telephone Number _____ DOS _____</p>	<p>Referred to:</p> <p>_____</p> <p style="text-align: center;">Name of Specialist/Specialty</p> <p>_____</p> <p style="text-align: center;">Address</p> <p>_____</p> <p style="text-align: center;">City/State/Zip</p> <p>_____</p> <p style="text-align: center;">Tax ID number/NPI number</p> <p>_____</p> <p>Telephone Number _____ DOS _____</p>
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<p>Referral Requested Because:</p> <p><input type="checkbox"/> Network Availability Uncertain</p> <p><input type="checkbox"/> Continuity of Care Issue</p> <p>Last Known Visit: _____</p> <p><input type="checkbox"/> Required by Health Plan</p> <p><input type="checkbox"/> Patient request because: _____</p>	<p>Services Requested Are:</p> <p><input type="checkbox"/> Consultation Only</p> <p><input type="checkbox"/> Consultation & Treatment</p> <p><input type="checkbox"/> # of Visits Requested</p> <p>For: _____</p> <p><input type="checkbox"/> 1 mo. <input type="checkbox"/> 3 mo. <input type="checkbox"/> 6 mo.</p> <p><input type="checkbox"/> 1 year</p> <p>_____</p>	<p>Other: Vendor Source or Facility</p> <p><input type="checkbox"/> Inpatient Stay* <input type="checkbox"/> Invasive Diagnostic <input type="checkbox"/> Hospice*</p> <p><input type="checkbox"/> ER <input type="checkbox"/> X-ray MRI CT <input type="checkbox"/> Chemo</p> <p><input type="checkbox"/> Outpatient Surg.* <input type="checkbox"/> Detox* <input type="checkbox"/> Med Supplies</p> <p><input type="checkbox"/> Home Health* <input type="checkbox"/> SNF* <input type="checkbox"/> Orthotics*</p> <p><input type="checkbox"/> DME Rent* <input type="checkbox"/> DME Purchase* <input type="checkbox"/> Other: _____</p> <p>* Prior Authorization Required</p>
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<p>Diagnosis and ICD Codes:</p>
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