SIHO Insurance Services Authorization Form

Phone: 800-553-6027

Please complete and fax to: 812-378-7054 or 317-860-3601

PATIENT NAME: _____DOB: ____ / ____ / _____

Patient ID #_____ Diagnosis (ICD-10 Code):_____

Date of Service:_____ / _____ / _____

REQUESTING PHYSICIAN NAME: _____

Contact Name:_____

Address: _____

Office Phone:_____ Contact Phone:_____ Office Fax:_____

Provider NPI:_____ Tax ID:_____ Vendor NPI:_____

VENDOR / FACILITY NAME / REFERRED-TO PHYSICIAN

Vendor NPI: _____Tax ID:_____

Name of Vendor/Facility/Physician: _____

Address: _____

Phone: _____ Fax: _____

DME **Contact Name: _____ Phone:_____**

☐ Rental $_____ Duration of use:_____

☐ Purchase $_____ Type of equipment/HCPCs: _____

*** Please attach as applicable: MD order, 02 sats, Compliance, Sleep Study, Improvement statement**

MEDICATIONS

Drug name:_____

☐ Other drugs tried and failed: _____

☐ Physician will be supplying and billing for medication

(Note: Otherwise, group pharmaceutical will be contacted for shipment of drug)

*** Must attach MD order and clinical information**

OUTPATIENT SERVICES

☐ PT / OT / ST (attach eval/Tx plan and script)

☐ MRI / CT / PET / Cardiac Scan

☐ Colonoscopy / EGD

☐ Sleep Study

☐ Acupuncture

☐ Outpatient Surgery

Procedure Codes: _____

☐ Inpatient Surgery Procedure Codes:

_____

_____

☐ Referral ☐ Retro

☐ Other: _____

_____

_____

_____

Please include any clinical information and physician orders to justify this request.

Review Date:11/23/2016. Revised Date: 08/25/2016