# SIHO Insurance Services Authorization Form

**To expedite – FULLY complete** **Fax: 812-378-7054 *or* 317-860-3601** **Phone: 800-553-6027**

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

**PATIENT NAME**: _____ DOB:_____/_____/_____

Patient ID# _____ Date of service: _____/_____/_____

**Diagnosis** (ICD-10): 1)_____ 2)_____ 3)_____

**REQUESTING PROVIDER**: _____ Phone: _____ Fax:_____

***(REQUIRED)*** Preparer's name/ Contact phone_____/_____

Address:_____

Provider NPI: _____Tax ID: _____ Vendor NPI:_____

**Vendor / Facility / Referred- to Provider**: _____

Address:_____

Phone: _____ Fax: _____

Vendor NPI: _____ Tax ID:_____

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

___ Rental $_____ Duration of use: _____

___ Purchase $_____ Type of equipment/ HCPCs:_____

*Please attach as applicable: MD order, O2 sats, Compliance, Sleep Study, Improvement statement

**MEDICATIONS** **Must attach script and clinical information* **J-Codes**_____

Drug Name: _____ Duration of treatment:_____

Other drugs tried and failed:_____

___Physician supplying & billing medication (Otherwise, group pharmaceutical will be contacted for shipment of drug)

**OUTPATIENT SERVICES (circle services)**

| | | |
|---|---|---|
| MRI / MRA / CT / PET / Cardiac Scan | PT / OT / ST | Radiation Therapy |
| Colonoscopy / EGD | Home Health Care | Mental Health |
| Outpatient surgery | Dialysis | Other_____ |

**Procedure Codes**:_____ Duration of treatment: _____

**INPATIENT SERVICES**

Inpatient Admission Date_____

Inpatient surgery : Procedure codes_____

___Referral

___Retro

(claim #_____)

*Internal use only*: Approval #_____ Effective dates: _____

Review 10/31/2017. Revised 10/31/2018.