

**To expedite** – Please submit your request online at [my.siho.org](http://my.siho.org)  
 Don't have an account? Contact your office administrator to get started.  
 Email: [auth.specs@siho.org](mailto:auth.specs@siho.org) Fax: 812-378-7054 Phone: 800-553-6027

Date and Time Submitted	
_____	_____
am/ pm	ET/ CT

**Section I – General Information**

Review Type <input type="checkbox"/> Non Urgent <input type="checkbox"/> Urgent	Clinical reason for urgency
Request Type <input type="checkbox"/> Initial Request	<input type="checkbox"/> Extension/Renewal/Amendment (Prev. Auth. #: _____ )

**Section II – Patient Information**

Name	Patient Contact Phone	DOB	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Member or Medicaid ID #	Group #		

**Section III – Provider Information**

Requesting Provider or Facility		Service Provider or Facility	
Name		Name	
NPI #	Group NPI#	NPI #	Group NPI#
Phone	Fax	Phone	Fax
Address		Address	
Tax ID		Tax ID	

**Section IV – Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)**

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD Version 10), if available	Code

Inpatient  Outpatient  Radiology  Provider Office  Observation  Home  Day Surgery  Oncology  Other (specify)

Physical Therapy  Occupational Therapy  Speech Therapy  Cardiac Rehab  Mental Health/Substance Abuse

Number of sessions: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

Home Health – **MD signed Order Required** (Nursing Assessment attached?  Yes  No)

Number of visits requested: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

DME – **MD signed Order Required**  Rental \$ \_\_\_\_\_ . \_\_\_\_\_ Per \_\_\_\_\_  Purchase \$ \_\_\_\_\_ . \_\_\_\_\_

Equipment/supplies (Include any HCPCS Codes): \_\_\_\_\_ Duration: \_\_\_\_\_

Medication – **MD signed Order Required**  MD Supplying and Billing OR  Retail

Duration of Use: \_\_\_\_\_ Number of Units: \_\_\_\_\_

**Section V – Extra Notes/Additional Codes**

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**Section VI – Clinical Documentation** – Please attach clinical documentation to support this request. If this request is for medication, please list other medications tried and failed when applicable.

Contact Name and Phone Number/Email regarding this request is \_\_\_\_\_