



Prior Authorization/Coverage Determination Form

Email: auth.specs@siho.org Fax: 812-378-7054 Phone: 800-553-6027 Online: www.siho.org

Section I – General Information

Review Type: <input type="checkbox"/> Standard <input type="checkbox"/> Expedite (currently inpatient or delay will be detrimental to patient’s life/ health)	Clinical reason to Expedite: _____ _____
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation <input type="checkbox"/> SNF <input type="checkbox"/> IP Rehab	
<input type="checkbox"/> Initial or Pre-Service Request <input type="checkbox"/> Extension/Renewal/Amendment (Previous auth #)	

Section II – Enrollee Information

Name: _____	Phone: _____	DOB: _____
Enrollee 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	End	Diagnosis (ICD Version 10)

Medication-**MD signed Order Required:**
 MD Supplying and Billing OR Retail

Outpatient Therapy:
 Physical Therapy Occupational Therapy Speech Therapy

DME-**MD signed Order Required:**
 Rental \$ _____ Per _____ OR Purchase \$ _____

Section VI — Clinical Documentation

Please attach **clinical documentation** to support this request. **If this request is for medication, please list other medications that are tried and failed when applicable.**

MD signed order required for DME, Medication, and Home Health Care

Contact Name and Phone Number/Fax regarding this request is:
Name: _____ Phone: _____ Fax: _____