



# REQUEST FOR AUTHORIZATION

State Form 55653 (R / 12-23)  
INDIANA DEPARTMENT OF HEALTH CHILDREN'S  
SPECIAL HEALTH CARE SERVICES (CSHCS)

The CSHCS Prior Authorization (PA) Unit telephone number is (800) 475-1355, or (317) 233-1351, then select the PA option.  
The CSHCS PA fax number is (317) 233-1342.

Name of contact		Telephone number and extension of contact		Fax number of contact		Date of request (mm/dd/yy)	
Name of service provider			Billing National Provider Identification (NPI) number			Tax identification number	
Address of service provider (number and street, city, state, and ZIP code)							
Name of service location							
Address of service location (number and street, city, state, and ZIP code)							
Name of participant				Participant number		Date of birth of participant (mm/dd/yy)	
Is this request for continuing service? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this request for an amendment to an existing PA? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, give the PA number	
Please indicate the type of service for which you are requesting prior authorization. <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Operating Room <input type="checkbox"/> Therapy <input type="checkbox"/> Supply <input type="checkbox"/> Durable Medical Equipment (DME) <input type="checkbox"/> Dental <input type="checkbox"/> Transportation <input type="checkbox"/> Home Health <input type="checkbox"/> Pharmacy* <input type="checkbox"/> Other: _____							
* Attention pharmacies: Please note that HCPCS procedure codes are required for supply / DME services. NDC codes are not accepted.							

\* Please note HCPCS codes are required for supplies / DME.

Start Date (mm/dd/yy) Required	Stop Date (mm/dd/yy) Required	Service Code* Required for Dental / Therapy / Supply / DME HCPCS / NDC	Service Description Required	Total Units Required	Purchase Yes / No	Rent Yes / No	Repair Yes / No	Frequency (if applicable)	Duration (if applicable)

Provider comments / additional information
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Documentation being sent (required) <input type="checkbox"/> Physician order <input type="checkbox"/> Copy of prescription <input type="checkbox"/> Medical notes <input type="checkbox"/> Test results <input type="checkbox"/> Discharge summary <input type="checkbox"/> Plan of care <input type="checkbox"/> Treatment notes <input type="checkbox"/> Medical documentation showing need for service <input type="checkbox"/> Admit notes for observation stay <input type="checkbox"/> History / physical <input type="checkbox"/> Other: _____
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### PRIOR AUTHORIZATION (PA) STATUS (FOR CSHCS USE ONLY – OPTIONAL)

Reviewed by:	Status <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Modified	PA number	Date of request (mm/dd/yy)
PA nurse comments			