Reset Form

REQUEST FOR AUTHORIZATION

State Form 55653 (8-14)
INDIANA STATE 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?	Is this request for an amendment to an existing PA?	If yes, give the PA number
☐ Yes ☐ No	☐ Yes ☐ No	

Please indicate the type of service for which you are requesting prior authorization.
☐ Inpatient ☐ Outpatient ☐ Emergency Room ☐ Operating Room ☐ Therapy ☐ Supply ☐ Durable Medical Equipment (DME)
☐ Dental ☐ Transportation ☐ Home Health ☐ Pharmacy* ☐ 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

Documentation being sent *(required)*
☐ Physician order ☐ Copy of prescription ☐ Medical notes ☐ Test results ☐ Discharge summary ☐ Plan of care ☐ Treatment notes
☐ Medical documentation showing need for service ☐ Admit notes for observation stay ☐ History / physical
☐ Other: _____

PRIOR AUTHORIZATION (PA) STATUS *(FOR CSHCS USE ONLY – OPTIONAL)*

Reviewed by:	Status ☐ Approved ☐ Denied ☐ Modified	PA number	Date of request *(mm/dd/yy)*

PA nurse comments