Indiana University Health

Indiana University Health Medical Management Authorization Request Form

Forward completed form via FAX to IUHMM at (317) 962-6219 or (317) 962-4005

REQUESTING PHYSICIAN INFORMATION

Ordering MD: ______________________________

****TAX ID**: ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

Contact: ______________________________

REQUESTING VENDOR INFORMATION

Vendor: ______________________________

****TAX ID**: ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

Contact: ______________________________

MEMBER INFORMATION

Name: ______________________________

ID#: ______________________________

DOB: ______/______/______

SS#: ________/________/________

Phone: ______________________________

********IUHMM USE ONLY********

AUTHORIZATION NUMBER______________

□ Services **APPROVED** As Requested

□ Request **MODIFIED** (see below for detail)

□ Request **DENIED**, Letter To Follow

Modifications Made:______________________________

IUHMM Staff:______________________________

Date:______________________________

Date of Service	CPT or HCPC Code	Requested Service	Place of Service INP OP OBS	Units	Diagnosis / ICD9 Code

CLINICAL SUMMARY (Form will be *rejected* if CLINICAL SUMMARY is NOT completed). (Send attachments, if needed).

____
____
____
____
____
____
____
____
____
____

SIGNATURE OF REQUESTING MD: ______________________________ **DATE**: ______________________