









Indiana University Health

## Indiana University Employee Health Plan Provider Information Guide

### Indiana University Quality Partners Identification Card:

All members will have an identification card.

 <b>INDIANA UNIVERSITY</b>	Medical Benefits Administrator: 
<b>Member</b>	<b>Medical Plan</b>
Group #: 7026000	 Business Solutions
Member: <b>JOHN SAMPLE</b>	<a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a>
Member ID: <b>SMPL0001</b>	Customer Service 866-844-9838
Plan:	<b>Copays:</b> Primary Care Physician: \$30 Specialist: \$40 / Urgent Care: \$75 ER: \$150 (waived if admitted)
PCP Name:	<b>Pharmacy Benefit</b>
	See Medco ID Card

<b>Medical Claims Submission</b>	<b>Eligibility &amp; Prior Authorization</b>
EDI: ID# 37283	This card does not guarantee coverage. For medical claim questions, verification of coverage, PPO Network questions, and hospital pre-authorization please contact HealthSmart Benefit Solutions, Inc.
Mail: HealthSmart Benefit Solutions, Inc. PO Box 93670 Lubbock, TX 79493-3670	Notification must be made prior to any hospital admission (Emergency admission within 48 hours) and other services listed in your plan document. Failure to call may result in reduced benefits.
	To verify coverage or find a network provider: <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a> 866-844-9838
<b>Travel Network</b>	
For assistance locating an urgent care facility or hospital out of area contact PHCS Healthy Directions 800-678-7427 / <a href="http://www.multiplan.com">www.multiplan.com</a>	
 PHCS	 MultiPlan
	 HPO



**Contact Information:**

<b>Eligibility/Benefits Verification/Claims Inquiry:</b>	<b>HealthSmart</b> 1-866-844-9838 <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a>  Call for instructions on how to obtain a user ID and password.
<b>Medical Prior Authorization:</b>	Services requiring authorization are listed below. Call or fax Authorization Request form to:  <b>IU Health Medical Management</b> Phone: 317-962-2378 or 866-492-5878 Fax: 317-962-6219 or 317-962-4005  Authorization Request Form can be obtained by calling the number above or at <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a>
<b>Claims Submission:</b>	<b>HealthSmart Benefit Solutions</b> PO Box 93670 Lubbock TX 79493-3670 EDI Submission #37283
<b>Rx Formulary:</b>	<b>IU Health Pharmacy Benefit Management</b> Phone: 317-963-3347 or 877-769-0191  Formulary and list of drugs included in Select \$4 Generic Drug Program available at <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a>  Certain drugs require prior authorization or have step therapy requirements. Requirements are noted on formulary list (PA or ST).
<b>Claim Disputes and Appeals:</b>	<b>HealthSmart Benefit Solutions</b> Phone: 866-844-9838 or Submit in writing to: HealthSmart Benefit Solutions PO Box 93670 Lubbock TX 79493-3670
<b>Drug Prior Authorization:</b>	<b>IU Health Pharmacy Benefit Management</b> Fax: 866-429-8920 Phone: 317-963-3347 or 877-769-0191  List of drugs requiring prior authorization can be obtained at <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a> To obtain authorization call or fax Universal Prior Authorization Form to fax number above.
<b>Provider Directory:</b>	<b>HealthSmart</b> <a href="http://www.healthsmart.com/iu.aspx">www.healthsmart.com/iu.aspx</a>
<b>Member Services:</b>	Refer member questions to:  <b>HealthSmart</b> Phone: 866-844-9838



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## Indiana University Health Employee Health Plan Services Requiring Prior Authorization

**ALL SERVICES PROVIDED BY OUT OF NETWORK PROVIDERS REQUIRE PRIOR APPROVAL**

Service Category	Prior Approval Required
Ambulance (non-emergent transport)	Yes
ABA Therapy	Yes
Behavioral Health Services	Partial Hospitalization Only
Bariatric Surgery	Yes
Durable Medical Equipment	Yes, except items with charges < \$500
Home Health Services	Yes
Hospice Services	Yes
Infertility Diagnosis	Yes
Injectable Drugs (in physician office)	Contact Pharmacy PA Coordinator Phone: 317.963.3347 or 877.769.0191
Inpatient Admissions	Yes
Observation Stays	Yes
Orthotic/Prosthetic	Yes, except items with charges < \$500
Out of Network Services	Yes
Plastic/Reconstructive Surgeries including but not limited to: Blepharoplasty Chin Implant Diastasis Recti Repair Lipectomy Mammoplasty Mentoplasty Osteoplasty Mandible Panniculectomy Prosthetic Material Collagen Implants (insertion or injection) Rhinoplasty	Yes
Rehabilitation Services - physical and occupational therapies	Yes, if treatment plan is >24 visits
Skilled Nursing Facility Services	Yes
Substance Abuse Services – Outpatient	Partial Hospitalization Only

Please contact IU Health Medical Management via phone for authorization request or fax Authorization Request form to:

IU Health Medical Management  
Phone: (317) 962-2378 or (866) 492-5878  
Fax: (317) 962-6219 or (317) 962-4005  
Hours: 8:30 to 4:30 Monday-Friday

Authorization Request Form is available at [www.healthsmart.com/iu.aspx](http://www.healthsmart.com/iu.aspx)



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## Indiana University Health Medical Management Authorization Request Form

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

<b>REQUESTING PHYSICIAN INFORMATION</b> Ordering MD: _____ **TAX ID: _____ Address: _____ Phone: _____ Fax: _____ Contact: _____	<b>REQUESTING VENDOR INFORMATION</b> Vendor: _____ **TAX ID: _____ Address: _____ Phone: _____ Fax: _____ Contact: _____
<b>MEMBER INFORMATION</b> Name: _____ ID#: _____ DOB: ____/____/____ SS#: ____/____/____ Phone: _____	<b>*****IUHMM USE ONLY*****</b> <b>AUTHORIZATION NUMBER</b> _____ <input type="checkbox"/> Services <b>APPROVED</b> As Requested <input type="checkbox"/> Request <b>MODIFIED</b> (see below for detail) <input type="checkbox"/> Request <b>DENIED</b> , Letter To Follow <b>Modifications</b> <b>Made:</b> _____ <b>IUHMM Staff:</b> _____ <b>Date:</b> _____

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).

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**SIGNATURE OF REQUESTING MD:** \_\_\_\_\_ **DATE:** \_\_\_\_\_