



Indiana University Health

Indiana University Health Medical Management Authorization Request Form

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

****Please complete all fields for review****

REQUESTING PHYSICIAN INFORMATION	REQUESTING VENDOR INFORMATION
Ordering MD: _____	Vendor: _____
**TAX ID: _____	**TAX ID: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Contact: _____	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:** _____