PHP PHYSICIANS HEALTH PLAN
THE INSURANCE YOUR HEALTH DESERVES

8101 West Jefferson Blvd.
Fort Wayne, IN 46804-4163
www.phpni.com

PRIOR AUTHORIZATION REQUEST FORM

Section I — Submission

Issuer Name	Phone	Fax	Date Submitted: _____
Physicians Health Plan	**(260) 432-6690**	**(260) 436-4809**	Time Submitted: _____ am/pm ET/CT

Section II — General Information

Review Type ☐ Non Urgent ☐ Urgent	Clinical reason for urgency
Request Type ☐ Initial Request	☐ Extension/Renewal/Amendment (Prev. Auth. #:)

Section III — Patient Information

Name	Patient Contact Phone	DOB	Sex ☐ Male ☐ Female ☐ Unknown
Subscriber Name (if different)	Member or Medicaid ID #	Group #	

Section IV — Provider Information

Requesting Provider or Facility		*Service Provider or Facility*	
Name		Name	
NPI #	Specialty	NPI #	Specialty
Phone	Fax	Phone	Fax
Contact Name and Phone		Name of Primary Care Provider (see instructions)	
Requesting Provider's signature and date (if required)		Phone	Fax

Section V — Services Requested (with CPT, CDT, or HCPCS Code) and Supporting Diagnoses (with ICD Code)

Planned Service or Procedure	*Code*	*Start Date*	*End Date*	*Diagnosis Description*	*Code*

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other (specify)

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of sessions Duration Frequency Other

☐ Home Health (MD signed Order attached? ☐ Yes ☐ No) (Nursing Assessment attached? ☐ Yes ☐ No)

Number of visits requested Duration Frequency Other

☐ DME (MD signed order attached? ☐ Yes ☐ No) (*Medicaid only:* Title 19 Certification attached? ☐ Yes ☐ No)

Equipment/supplies (Include any HCPCS Codes) Duration

Section VI — Clinical Documentation (See Instructions Page, Section VI)

In place of documentation in this area, please attach information required for the service.

If PHP needs more information, PHP may call the requesting provider or authorized representative directly at: _____ _____ (ext. _____) or via email at _____. Preferred method of contact is ☐ phone or ☐ email.

Section VII — Reason for Denial or Partial Denial (To be completed by the issuer)

If denied, PHP will send letter within 72 hours stating the reason for any denial.

Please submit the completed form(s) to PHP Medical Management at medmanfax@phpni.com or by fax to (260) 436-4809.

PHP PHYSICIANS HEALTH PLAN
THE INSURANCE YOUR HEALTH DESERVES

PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES FOR USE IN INDIANA

Please read all instructions before completing the form.
Do not send the completed form to the Indiana Department of Insurance or to the patient's or subscriber's employer.

The Indiana Department of Insurance encourages all insurers, HMOs, administrators, and others to accept the Standardized Prior Authorization Request Form for Health Care Services for use in Indiana if the plan requires prior authorization of a health care service.

Intended use: When an issuer requires prior authorization of a health care service, use this form to request the authorization **by mail**. An issuer may also provide on its website an **electronic version of this form** that can be completed and submitted to the issuer electronically via the issuer's portal.

Do not use this form: 1) to request an appeal, 2) to confirm eligibility, 3) to verify coverage, 4) to ask whether a service requires prior authorization, 5) to request prior authorization of a prescription drug, or 6) to request a referral to an out of network physician, facility or other health care provider.

Additional information and instructions:

Section I. An issuer may have already prepopulated its contact information on the copy of this form posted on its website.

Section II. *Urgent reviews:* Request an urgent review for a patient who is currently hospitalized, ***or*** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review, to prevent a serious deterioration of the patient's condition or health.

Section IV.
- If the *Requesting Provider or Facility* will also be the *Service Provider or Facility*, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, radiology studies, etc.), if needed.

Section VII.
- Give a brief narrative of why the request was denied or partially denied.

Note: Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before transmitting your request.

If the requesting provider wants to be called directly about missing information that the issuer must have to process this request, and the provider's contact information is not the contact information listed in Section IV, enter the provider's contact information in the space given at the bottom of the request form. *This call is intended only to ensure that the issuer receives the information it needs to review the request. It is **not** a peer-to-peer discussion afforded by a utilization review agent (URA) before issuing an adverse determination.*