

**INDIANA CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)
AUTHORIZATION REQUEST (TEST FORM 2328B4)**

Contact Name	Contact Phone/Extension	Contact Fax Number	Date of Request
Service Provider Name/Address	Billing NPI Number	Service Location Name/Address	
	Tax ID Number		
Participant Name	Participant Number	Participant DOB	
Is this request for continuing service? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is this request for an amendment to an existing PA? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, please give PA Number	

CSHCS PA Unit Phone: (800) 475-1355 then select PA option, or (317) 233-1351 CSHCS PA Fax:(317) 233-1342

Please indicate the type of service for which you are requesting prior authorization below.

Inpatient Outpatient ER OR Therapy Supply 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.

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 Y/N	RENT Y/N	REPAIR Y/N	FRE- QUENCY If Applicable	DURATION If Applicable

*Please note HCPCS codes are required for supplies/DME.

PROVIDER COMMENTS/ADDITIONAL INFORMATION

DOCUMENTATION BEING SENT (**REQUIRED**)

Physician Order Copy of RX Medical Notes Test Results Discharge Summary Medical Documentation Showing Need for Service
Plan of Care Treatment Notes Admit Notes for Observation Stay History/Physical Other _____

PA STATUS (**FOR CSHCS USE ONLY-OPTIONAL**)

REVIEWED BY	APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> MODIFIED <input type="checkbox"/>	PA NUMBER	DATE
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PA NURSE COMMENTS: