Indiana Health Coverage Programs (IHCP)
Full Eligibility Notification Form

Provider Name:

Provider Fax Number:

Date:

The following individual shows eligibility for the Healthy Indiana Plan. Your facility sent us a Fast Track notification for this individual. Please refer to the IHCP Provider Healthcare Portal for the member's benefit package information.

INDIVIDUAL ELIGIBILITY INFORMATION	
First Name	
Middle Initial	
Last Name	
Date of Birth	
Date of Admission	
Member Managed Care Entity (MCE)	
Member ID (also known as RID)	

Your facility has 60 days from the date of this notification to submit a prior authorization (PA) request for the service that was rendered prior to the member's full eligibility determination. You must include this notification with your PA request so that the request may be adjudicated as a timely request.