Indiana Health Coverage Programs
Prior Authorization Revision Request Form

Date: ____________________ Requesting provider NPI: ______________________________________

Mail-to Provider ID: ____

Service location: ____

Provider name:____

Contact person: ____

Telephone: ____

Member name: ____

Member ID (RID): ____

Prior authorization #: ____

Service code (CPT/modifier/taxonomy, HCPCS, ICD and so forth):

____

Summary of requested actions:

Changes prompting the PA revision request:

Prior Authorization Department use only

Reviewer: ____

Date system: ____

Update: ____

Decision and comments:

See the *IHCP Provider Quick Reference* at in.gov/medicaid/providers for mailing address or fax number. A copy of the decision will be provided to the requesting provider and to the member. **NOTE**: Prior authorization revision requests can also be submitted via the Atrezzo Provider Portal.