INDIANA HEALTH COVERAGE PROGRAMS FORMS REQUEST

Name __________________________________________ Provider number __________________________
Street address ____________________________________________________________
City __________________________ State _______ ZIP code ______________
Attention ________________________________________________________________

Please indicate the quantity requested in the blank next to the form name.

590 Program
    ___ 590 Program Enrollment/Discharge/Transfer (EDT)
    ___ Provider Authorization (590 Program Membership Information for Outside the 590 Program Facility)
    ___ FSSA OMPP 590 Program Facilities Agreement

Care Select
    ___ Care Select Provider Referral Form
    ___ State Psychiatric Hospital Care Select Disenrollment/Enrollment form

Claims Forms (NonPharmacy)
    ___ Attachment Cover Sheet
    ___ Claim Certification Statement for Signature on File
    ___ HHS-687 (05/10) - Consent for Sterilization (English)
    ___ HHS-687-1 (11/06) - Consent for Sterilization (Spanish)

Claim Adjustment Forms (NonPharmacy)
    ___ CMS-1500, Dental, Crossover Part B Paid Claim Adjustment Request Form
    ___ UB-04 and Inpatient/Outpatient Crossover Adjustment Request Form

CPS Request for Settlement
    ___ CPS Request for Settlement Form

EDI Outbound Transactions Request
    ___ EDI Outbound Transactions Request

Financial Forms
    ___ Electronic Funds Transfer (EFT) Form within the Provider Update Form
    ___ IRS W-9 Form

Hospice Forms
    ___ Hospice Accounts Receivable Refund Adjustment
    ___ Medicaid Hospice Plan of Care
    ___ Change in Status of Medicaid Hospice Patient
    ___ Hospice Provider Change Request Between Indiana Hospice Providers
    ___ Medicaid Hospice Discharge
    ___ Medicaid Hospice Revocation
    ___ Medicaid Hospice Physician Certification
    ___ Medicaid Hospice Election
    ___ Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents

Long Term Care (LTC) Forms
    ___ Certification Statement by Medicaid-Enrolled Nursing Facilities
    ___ Long Term Care (LTC) Nursing Home Administrators FAX Procedures to obtain PDF information for multiple residents
    ___ Nursing Facility Level of Service State Authorization and Data Entry Form
    ___ Physician Certification for Long-Term Care Services Form

Medicaid Behavioral/Physical Health Coordination
    ___ Medicaid Behavioral/Physical Health Coordination Form

Medical Clearance Forms and Certifications of Medical Necessity
    ___ Augmentative Communication System Selection Form
    ___ Certification of Medical Necessity: Oxygen
    ___ Certification of Medical Necessity: Parenteral and Enteral Nutrition
    ___ Medicaid Second Opinion Form
    ___ Medical Clearance Form for Hearing Aids
    ___ Medical Clearance Form for Hospital Beds
    ___ Medical Clearance Form for Motorized Wheelchair Purchase
Medical Clearance Form for Negative Pressure Wound Therapy
Medical Clearance Form for Non-Motorized Wheelchair Purchase
Medical Clearance Form for Standers
Medical Clearance Form for TENS Unit

National Provider Identifier (NPI) Forms
NPI Reporting Form

Pharmacy Forms
17-P Prior Authorization Request Form
Anti-Ulcer Medications (Carafate and Cytotec) PA Form
Forteo Prior Authorization Request Form
FSSA: Manufacturer PDL Submission Application, Checklist, Notice of Intention, Manufacturer Responsibilities, and Timeline
Growth Hormone PA Form for Age Less Than 18 - Effective January 1, 2010
Growth Hormone PA Form for Age Greater Than or Equal to 18
Indiana Medicaid Compound Prescription Claim Form
Indiana Medicaid Pharmacy Claims Attachment Cover Sheet
Indiana Medicaid Drug Claim Form (NCPDP Pharmacy Paper Claim Form)
Mental Health Quality Advisory Committee (MHQAC) Medical Necessity Review/PA Form
Multiple Sclerosis Agents Prior Authorization Request Form
PBM Call Center LTC ProDUR and Home Health Prior Authorization Request Form
PBM Call Center Prior Authorization Request Form
Pharmacy Paid Claim Adjustment Request Form
Pharmacy Billing Instructions
POS Reversal Void Request Form
Suboxone/Subutex Initiation Prior Authorization Form
Suboxone Renewal Prior Authorization Form
Synagis Prior Authorization Form

Prenatal Care Coordination Forms
Prenatal Care Coordination Initial Assessment
Prenatal Care Coordination: Operational Guidelines for Initial Assessment
Prenatal Care Coordination Letter of Findings (Initial Assessment Results)
Prenatal Care Coordination Reassessment
Prenatal Care Coordination: Operational Guidelines for Reassessment
Prenatal Care Coordination Assessment Update Letter (Reassessment Results)
Prenatal Care Coordination Narrative Notes
Prenatal Care Coordination Outcome Report
Prenatal Care Coordination: Operational Guidelines for Outcome Report

Prior Authorization
Prior Authorization - System Update Request Form
Prior Review and Authorization Dental Request Form
Medicaid Appeal Request Form
Universal Prior Authorization Request Form
Universal Prior Authorization Request Form – Instructions

Provider Correspondence Forms
Indiana Health Coverage Programs Forms Request
Indiana Health Coverage Programs Inquiry – for submitting a written inquiry on nonpharmacy issues
Policy Consideration Form

Provider Enrollment Forms
To request Provider Enrollment forms, please call Provider Enrollment Customer Assistance at 1-877-707-5750.

Third Party Liability (TPL) Forms
Credit Balance Worksheet
Credit Balance Worksheet Instructions
Medicaid Third Party Accident/Injury Questionnaire
Medicaid Third Party Liability Questionnaire
Provider TPL Referral Form
Request for Medicaid Pregnancy and Birth Expenditures

Send requests to the following address:
HP Forms Request
P. O. Box 7263
Indianapolis, IN 46207-7263