Good Samaritan Direct Health

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Pre-Authorization Request Form

To expedite – Please submit your request online at www.siho.org
Don't have an account? Contact your office administrator to get started.
Fax: 812-378-7054 Phone: 888-690-3044

Date and Time Submitted
_____
am/ pm ET/ CT

Section I — General Information

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

Section II — Patient Information

Name	Patient Contact Phone	DOB	Sex ☐ Male ☐ Female ☐ Unknown
Member or Medicaid ID #		Group #	

Section III — Provider Information

Requesting Provider or Facility		*Service Provider or Facility*	
Name		Name	
NPI #	Group NPI#	NPI #	Group NPI#
Phone	Fax	Phone	Fax
Address		Address	
Tax ID		Tax ID	

Section IV — 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 (ICD Version 10), if available*	*Code*

☐ Inpatient ☐Outpatient ☐Radiology ☐Provider Office ☐Observation ☐Home ☐Day Surgery ☐Oncology ☐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 Required** (Nursing Assessment attached? ☐Yes ☐No)

Number of visits requested: Duration: Frequency: Other:

☐DME – **MD signed Order Required** ☐Rental $_____ . ____ Per _____ ☐Purchase $_____ . ____

Equipment/supplies (Include any HCPCS Codes): Duration:

☐Medication – **MD signed Order Required** ☐ MD Supplying and Billing OR ☐Retail

Duration of Use: Number of Units:

Section V — Extra Notes/Additional Codes

Section VI — Clinical Documentation – Please attach clinical documentation to support this request. If this request is for medication, please list other medications tried and failed when applicable.

Contact Name and Phone Number/Email regarding this request is _____