Indiana Health Coverage Programs (IHCP)
Fast Track Notification Form

INSTRUCTIONS
Any Indiana Health Coverage Programs (IHCP) provider that assists an individual with a Fast Track prepayment and renders services prior to a final eligibility determination may complete this form to notify the appropriate managed care entity (MCE) of a forthcoming request for retroactive prior authorization (PA). ***Please note:*** • All PA requests will require documentation of medical necessity and must meet all applicable prior authorization standards. • A Fast Track prepayment is not a guarantee of coverage or eligibility. • If full eligibility is not determined within 60 days of this form's submission, the applicable MCE will consider this form void.

INDIVIDUAL CONTACT INFORMATION	
First Name	
Middle Initial	
Last Name	
Date of Birth	
Last Four Digits of Social Security Number	
Date of Admission	
Date of Fast Track Prepayment	

FACILITY CONTACT INFORMATION *Please include the appropriate individual who will be notified upon eligibility determination.*	
Facility Name	
Point of Contact	
Telephone Number	
Fax Number	

FACILITY AGREEMENTS
☐ I agree not to submit a PA request for this individual until eligibility is determined. ☐ I agree not to submit a claim for services rendered for this individual until eligibility is determined. ☐ I attest that a Fast Track prepayment for this individual has been made.