



IV Infusion Services Prior Authorization Form

Fax Form To: 313.748.1312

Member

Last Name: _____

First Name: _____

THC ID # _____

DOB: _____

Diagnosis/Condition: _____

ICD-10 code: _____

Medication/Solution Requested:

CPT/HCPC code:

1. _____

_____ Strength: _____

Frequency: _____ time(s) per: day week month

Duration: _____ Total Units: _____

2. _____

_____ Strength: _____

Frequency: _____ time(s) per: day week month

Duration: _____ Total Units: _____

3. _____

_____ Strength: _____

Frequency: _____ time(s) per: day week month

Duration: _____ Total Units: _____

4. _____

_____ Strength: _____

Frequency: _____ time(s) per: day week month

Duration: _____ Total Units: _____

RN visits provided by Home Infusion Provider? Yes No

(automatic auth will be 3 to teach then one weekly)

Duration of treatment: Start Date: _____ End Date: _____

Frequency: _____ time(s) per: day week month

Provider of RN care: _____

Please note: This process does not replace medication authorizations that require prior authorization through the pharmacy department.

Requesting Physician Information:

Provider Name: _____

Phone: _____

Contact Name: _____

Servicing IV Infusion Provider Information:

Company Name: _____

Phone: _____ Ext: _____

Contact Name: _____

Tax ID #: _____

NPI: _____

Authorization Process for Home Care Services:

Vendor receives an order for home care therapy.

Vendor will complete this authorization form and fax it to 313.748.1312. Include a call back number and contact name.

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THC form ID: _____