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.

THC form ID: _____