PASSPORT HEALTH PLAN

HOME INFUSION AUTHORIZATION FORM

Date: _____ Auth #: _____ 19.6.4

Fax to: **502-213-8958** PHP R.N. Initials: _____

Attn: **PHP Home Health**

MEMBER INFORMATION

AUTHORIZATION NUMBER _____

MEMBER'S NAME _____

PASSPORT ID _____ MEMBER'S DOB _____

IF MEDICARE PRIMARY, PROVIDE REASON AS TO UABLE TO BILL MEDICARE _____

_____

PROVIDER INFORMATION

ORDERING MD _____

PROVDER ID _____ PROVIDER CONTACT _____

REQUESTING PROVIDER _____

PROVIDER PHONE _____ PROVIDER FAX _____

CLINICAL INFORMATION

INITIAL REQUEST? ❑ YES ❑ NO IF NO: NUMBER OF VISITS TO DATE _____ DATE OF LAST VISIT _____

DIAGNOSIS _____

DIAGNOSIS **ICD10** CODE _____

INFUSION THERAPY REQUESTED WITH DATES OF SERVICE _____

CLINICAL SUMMARY _____

_____

_____

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