



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

HealthLink Home Infusion Pre-Review Program

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Agency's Name: _____
 Address _____
 Phone No. _____ Fax No(Required) _____

Enrollee Information

Patient's Name: _____
 ID Number _____ Patient's DOB: _____
 Address _____
 Height: _____ Weight: _____ Daytime Phone No. _____

Ordering Physician Information

Physician Name _____
 Address _____
 Phone No. _____ Fax No. _____
 TIN: _____
 Referred to Agency from: Hosp SNF REHAB OTHER

Treatment Information

Diagnosis: _____
 Home Health Care Home Infusion

Past Medical History: _____

Where will patient reside Own Home SNF OTHER

Does the Patient have a Primary Care Giver YES NO

If **yes**, please specify: _____
 Relationship to Patient: _____

Social Factors (family, community services): _____

Services Requested:

Medication of Service	Dosage	Route	Frequency	Start Date	Stop Date

Rates include skilled Nursing YES # of Visits _____
 NO

Are skilled nursing visits required or is this request just for the medication _____

Skilled Nursing Visits plan of care: _____

Type of IV access: _____

Will blood draws and IV access care be needed YES NO

If so, how often during the week _____

Is there anyone in the home who can be trained to give the medication YES NO

Is this IV infusion being given in the home or outpatient setting _____

Is another facility providing home skilled nursing for another condition for this member YES NO

If so, what is the name of the facility _____

Additional Comments:

Contact Information

Contact Person _____

Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

**The Plan has a preferred Home Infusion provider. In order to receive the maximum benefit, the preferred provider must be used.*

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.