Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Home Infusion Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This notification reference 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 Name: _____

Address: _____

Phone: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address: _____

Phone: _____

Ordering Physician Information

Physician Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Referred to Agency from: ☐ Hospital ☐ SNF ☐ Rehab ☐ Physician ☐ Other

If Physician or Other please specify: _____

Treatment Information

Diagnosis (ICD-10) Code: _____

Pertinent Medical History (submit history, physical and include previous treatments and dates): _____

_____

_____

Where will patient reside? ☐ Home ☐ SNF ☐ Other

If other, please specify: _____

Does the patient have a Primary Care Giver? ☐ YES ☐ NO

If yes, please specify: _____

Relationship to Patient: _____

Home Status/Social Support: _____

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.

Services Requested:

Medication	Dosage	Route	Frequency	Start Date	Stop Date

Rates include skilled Nursing ☐ YES # of Visits _____

☐ NO

Are skilled nursing visits required? ☐ YES ☐ NO

If yes, Skilled Nursing Visits plan of care: _____

_____

Will blood draws and IV access care be needed? ☐ YES ☐ NO

If yes, how often during the week? _____

Type of IV access: _____

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

Is this IV infusion being given? ☐ Home ☐ Outpatient

If outpatient, please specify: _____

Is another agency providing home skilled nursing for another condition for this member? ☐ YES ☐ NO

If yes, what is the name and phone number of the agency? _____

Additional Comments

_____

_____

_____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

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