

Authorization Form
IV Infusion Services
Fax Form To: 616 975-8885
Attn: Home Health Care



Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Diagnosis/Condition: _____

Medication/Solution Requested:

Code:

_____	_____
_____	_____
_____	_____
_____	_____

RN visits provided by Home Infusion Provider? Yes No

RN _____ + _____ = _____ (automatic auth will be 3 to teach then one weekly)

Provider of RN care: _____

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

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: _____

Requesting IV Infusion Provider Information:

Company Name: _____ Phone: _____ Ext: _____

Contact Name: _____ Tax ID#: _____

Authorization Process for Home Care Services:

Vendor receives an order for home care therapy.

Vendor will complete this authorization form and fax it to 616 975-8885. Include a call back number and contact name.

Authorization confirmation will be available within 3 business days via Auth Inquiry in the online Provider Center at *priorityhealth.com*. Once logged in to the Provider Center, select Auth Inquiry from the tools on the right. Need a login for our Provider Center? Contact the Provider Helpline at 800 942-4765.

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