



Home Infusion Therapy Authorization Form

Infusion Therapy Provider	Provider Phone Number	Member's Group Name
Infusion Therapy Provider Address	Provider Fax Number	Member's Group Number
Infusion Therapy Provider Address	Provider Number	Member Number w/ Prefix

Agency Contact Name:		SOC Date:		Date of Request:	
Patient's Last Name:		First Name:	M.I.	Gender:	Date of Birth:
Address (Street, Number, City, State & Zip)		Name of Contract Holder:		Relationship to Contract Holder: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> other (specify) _____	
Place of Hospitalization:			Admission Date:	Discharge Date:	
Primary and Secondary Diagnosis Code(s):			Services Requested:		
Name and Address of Attending Physician:			Physician's Telephone Number:		
Complicating Factors: <input type="checkbox"/> Diabetes <input type="checkbox"/> Pediatric <input type="checkbox"/> Lack of Family <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Multiple Needs <input type="checkbox"/> Poor Access <input type="checkbox"/> Neutropenic <input type="checkbox"/> Receiving Chemo			Access: <input type="checkbox"/> Peripheral <input type="checkbox"/> Central Line <input type="checkbox"/> Single <input type="checkbox"/> Double <input type="checkbox"/> Triple <input type="checkbox"/> Midline <input type="checkbox"/> PICC <input type="checkbox"/> Cutdown <input type="checkbox"/> Other (specify) _____		
Lab work to be performed: Frequency _____ Type _____			Method of Administration: <input type="checkbox"/> Gravity <input type="checkbox"/> Other(specify) <input type="checkbox"/> Pump (specify) _____		
Instruction:					
Authorization Requested (Drugs, frequency, supplies, etc.):					

Internal Office Use Only

Certification # and Dates	

Important Please Read

1. Claims submitted for these benefits are subject to lifetime maximums, any applicable deductions, or coinsurances or provisions as specified in the contract. Benefits will be subtracted from the patient's lifetime benefits. This approval is subject to the following conditions: a) the membership is in effect at the time the services are rendered, b) these specific benefits are available under the particular contract for which the patient is insured, and c) non-exhaustion of lifetime benefits. In order to assure that benefits are available under patient's contract, please contact the appropriate benefit and eligibility verification area.
2. Payment of the claim for the approved services does not mean that future services will automatically be paid. All future claims for services similar to the above services have to be evaluated in accordance with the existing criteria.
3. If you have any questions regarding the extent of this authorization, please call (800) 334-3427 ext. 4402. Calls will be responded to within one business day.

Fax completed form to (410)720-5630 or (410)720-5641.

Please contact provider services to verify member's eligibility and benefits for the requested service.

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