

# Authorization Form

## IV Infusion Services

### 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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