



PO Box 9201 Austin, TX 78766  
Phone: 855-266-2093  
Fax: 866-502-0297

## INFUSION THERAPY PRE-AUTHORIZATION FORM

**\*\*\*Please complete and submit all requested information at least 72 hours prior to date of service\*\*\***

**PROVIDER AND FACILITY MUST BE IN-NETWORK \* For Benefits and Network Status, call Boon Chapman at 855-266-2093**

Following Must Be Included: Patient's History & Physical, Clinical/Medical Records pertinent to the request, and Previous Treatment (including medication, therapy with response to treatment, diagnostic testing performed with results)

### Patient Information

Patient Full Name:  Male  Female  
Patient DOB:  Member ID:   
Patient Phone Number:  Group Name:

### Ordering Provider Information

Ordering Physician/Provider:   
Tax ID:   
Office Phone Number:   
Office Fax Number:   
Office Contact Person:   
Street Address:   
City:   
State:   
Zip Code:

### Servicing Provider Information

Hospital/Facility/Specialist:   
Tax ID:   
Office Phone Number:   
Office Fax Number:   
Office Contact Person:   
Street Address:   
City:   
State:   
Zip Code:

If there is an adverse determination, would you like a PEER to PEER?

Yes  No

Provider Name:

Phone Number:

Best Time to Contact:

**Please see second page to complete Infusion Therapy information**

#### Confidential Health Information Enclosed

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

**Fax this form to PRIME Dx at 866-502-0297**



## INFUSION THERAPY PRE-AUTHORIZATION FORM (Cont.)

### Infusion Therapy Information

ICD Code & Diagnosis:  
Date Diagnosed:  
How was diagnosis made:  
Plan of Care:  
Start Date (Date of Service):

Drug/J Code	Dose	Frequency	Duration

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