



Infusion Therapy Authorization Form

Circle: Univera Healthcare Univera PPO SeniorChoice Medicare PPO PlusMed Child Health Plus
Family Health Plus Other: _____

Member Name: _____ Provider ID.# _____

Insurance I.D. #: _____ Provider Name : _____

M.D. Ordering: _____ DX / ICD9 Code: _____

Type of Infusion Line: _____ Number of Lumens: _____

Drug/ Dosage/ Frequency: _____

Requested D.O.S.: _____ to _____ Infusion Category (i.e. anti-infective, chemo): _____

Per Diem Code: _____ # of Units: _____ Price per Unit: _____

J Code: _____ # of Units: _____ Price per Unit: _____

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Drug/ Dosage/ Frequency: _____

Requested D.O.S.: _____ to _____ Infusion Category (i.e. anti-infective, chemo): _____

Per Diem Code: _____ # of Units: _____ Price per Unit: _____

J Code: _____ # of Units: _____ Price per Unit: _____

J Code: _____ # of Units: _____ Price per Unit: _____

J Code: _____ # of Units: _____ Price per Unit: _____

**** If J3490 utilized, the NDC number must be included next to the "J" code. Please also attach a copy of the script with the authorization request.*

Nursing visits frequency requested: _____

If the number of visits exceeds the suggested guidelines, please give explanation for further visits:

Number of Nursing visits authorized: _____ Code: _____

Authorization # _____ Authorization received from: _____