

Two Chase Corporate Drive, Suite 300
Hoover, AL 35244
205-423-1222 or 1-800-962-3018
Fax 205-444-4284



Request for IV Home Care Services Authorization

Provider: _____ Contact: _____
Phone: _____ Fax: _____

Patient: _____ Date: _____
Dates of Services: From _____ to _____
Member ID#: _____
Diagnosis: _____ ICD9: _____
Physician: _____

Number of visits requested (outside per diem) (with frequency):

Skilled Nurse: _____ (S9123)

Social Worker: _____

Physical Therapist: _____

Speech Therapist: _____

Occupational Therapy: _____

Home Health Aide: _____

IV Home Care: Drug: _____ Codes: _____
Dose: _____
Number of days to be administered: _____ Dates: _____
Per diem: _____ (2SN/WK) Delivery Fee if applicable: _____

FOR HEALTHSPRING PATIENT'S DELIVER THE MEDICARE NON-COVERAGE NOTICE TO MEMBER 2 DAYS or 2 VISITS PRIOR TO ENDING OF HOME CARE SERVICES AND FAX A SIGNED COPY TO HEALTHSPRING.

FOR ADDITIONAL VISITS, PLEASE SUBMIT REQUEST WITH CLINICAL INFORMATION SUPPORTING PLAN OF CARE.

Verbal Order from Dr. _____
Received by: Name/ Title: _____

Authorization Number: _____
Dates of Service Approved: _____
Services Approved: _____
Contact Person is: _____ Phone Number: _____

This authorization is for medical necessity only and not a guarantee of payment. Eligibility is determined at the time the claim is received and benefits are subject to the limitations and exclusions of the member's plan.