



**Mailing Address:** BlueCross BlueShield of Tennessee  
 P.O. Box 180205  
 Chattanooga, TN 37402  
 Fax: 1-888-535-5243 or (423) 535-5243

## Medicare Advantage PPO<sup>SM</sup> HIT Prior Authorization Fax Form

Patient's Name (First, middle, last name)	Patient's ID Number	Patient's Date of Birth
Patient's Address (Street, city, state, zip)	Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Insurance Coverage: <input type="checkbox"/> Medicare <input type="checkbox"/> BlueCare <input type="checkbox"/> TennCare Select <input type="checkbox"/> Other

**Member Information**

<b>Primary Diagnosis:</b> ICD-9 Code:	<b>HIT Related Diagnosis:</b> ICD-9 Code:	<b>Other Diagnosis:</b> ICD-9 Code:
<b>Supportive Documentation Attached:</b> <input type="checkbox"/> Signed Doctor's Orders <input type="checkbox"/> Clinical History <input type="checkbox"/> Culture & Sensitivity <input type="checkbox"/> Misc. Lab	<b>Justification for Home Infusion Therapy:</b>	<b>Dates of Service for this authorization</b> From: _____ To: _____
<b>Daily Administration Schedule for this Infusion Therapy</b> Continuous? <input type="checkbox"/> Yes <input type="checkbox"/> No Pump Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Type of HIT Therapy</b> <input type="checkbox"/> IV Hydration <input type="checkbox"/> TPN <input type="checkbox"/> Enteral <input type="checkbox"/> PO <input type="checkbox"/> IV Drug Administration <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Aerosol <input type="checkbox"/> Other	
Is the patient receiving private duty nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient receiving any skilled nursing services in addition to home infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Service? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Reference #</b>	<b>Date of last Service:</b>	

HCPCS code	Drug/Supplement with Dosage and Frequency <small>*Code J3490 requires NDC Number</small>	Route of Administration					Total Units Requested
		IV	IM	SQ	Tube	Other	

<b>Per Diem</b>	
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<b>Physician's Name</b>	<b>Provider#</b> NPI Tax ID# (last 5 digits)	<b>Physician's Address</b> (Street, city, state, zip)	<b>Telephone Number</b> ( ) <b>FAX Number</b> ( )
<b>Infusion Agency's Name</b>	<b>Provider#</b> NPI Tax ID# (last 5 digits)	<b>Infusion Agency's Address</b> (Street, city, state, zip)	<b>Telephone Number</b> ( ) <b>FAX Number</b> ( )
<b>Contact Person</b>	<b>Signature</b>	<b>Title</b>	<b>Date</b>

**NOTE: Doctor's orders, clinical information, & appropriate lab must be received with the request for service or within two (2) business days of receiving the initial request for service.**

Call In Prior Authorizations 1-800-924-7141 Medicare Advantage Customer Service 1-800-841-7434 or 1-888-423-9490 TTY (hearing impaired) between the hours of 8am-9pm (ET), 7 days a week. Note: From March 2 to September 30, you may be required to leave a voicemail on holidays and weekends. Your call will be answered within one business day.