BlueCross BlueShield of Tennessee

www.bcbst.com

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BlueCare® TennCare℠ *Select*

HIT Request Form

Member Information:

Patient's Name (First, Middle, Last)	Patient's ID (SS) Number	Patient's Date of Birth
Patient's Address (Street, City, State, ZIP)	Patient's Sex ❑ Male ❑ Female	Primary Insurance Coverage: ❑ Medicare ❑ BlueCare® ❑ TennCare℠ *Select* ❑ Other

Primary Diagnosis: **ICD-9 Code:**	**HIT Related Diagnosis:** **ICD-9 Code:**	**Other Diagnosis:** **ICD-9 Code:**
Supportive Documentation Attached: ❑ Signed Doctor's Orders ❑ Clinical History ❑ Culture & Sensitivity ❑ Misc. Lab	**Justification for Home Infusion Therapy (HIT):**	**Dates of Service for this Reference:** From: _____ To: _____

Daily Administration Schedule for this Infusion Therapy:
Continuous? ❑ Yes ❑ No
Pump Required? ❑ Yes ❑ No

Type of HIT Therapy

❑ IV Hydration ❑ TPN ❑ Enteral ❑ PO
❑ IV Drug Administration ❑ Chemotherapy ❑ Aerosol ❑ Other

Is this patient receiving private duty nursing?
❑ Yes ❑ No

Is this patient receiving any skilled nursing services in addition to home infusion? ❑ Yes ❑ No

Previous Service? ❑ Yes ❑ No **Reference #:** _____ **Date of Last Service:** _____

HCPCS*	**Drug/Supplement with Dosage and Frequency** *Code J3490 Requires NDC Number	**Route of Administration**					**Total Units Requested**
		IV	**IM**	**SQ**	**Tube**	**PO**	
Per Diem							
Per Diem							

Physician and Supplier Information:

Physician's Name	BlueCross BlueShield of Tennessee Provider Number	
Physician's Address (Street, City, State, ZIP)	Telephone Number ( )	Fax Number ( )
Infusion Agency's Name	BlueCross BlueShield of Tennessee Provider Number	
Infusion Agency's Address (Street, City, State, ZIP)	Telephone Number ( )	Fax Number ( )
Contact Person	Title	
Signature **X**	Date	

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

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