of Tennessee
plans for better health. plans for a better life.℠
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Commercial HIT Authorization Form

MEMBER INFORMATION

Patient's Name (First, middle, last name)	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**	**Dates of Service for this authorization** 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 the patient receiving private duty nursing? ☐ Yes ☐ No	Is the patient receiving any skilled nursing services in addition to home infusion? ☐ Yes ☐ No	
Previous Service? ☐ Yes ☐ No **Reference #**	**Date of last Service:**	

J code	Drug/Supplement with Dosage and Frequency *Code J3490 requires NDC Number	Route of Administration IV	IM	SQ	Tube	Other	Total Units Requested
Per Diem							
Per Diem							

PHYSICIAN AND SUPPLIER INFORMATION

Physician's Name	BCBST Provider Number	Physician's Address (Street, city, state, zip)	Telephone Number ( ) FAX Number ( )
Infusion Agency's Name	**BCBST Provider Number**	**Infusion Agency's Address (Street, city, state, zip)**	**Telephone Number ( ) FAX Number ( )**

Contact Person	Signature	Title	Date

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.