



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402
www.bcbst.com

**THIS INFORMATION IS
CONFIDENTIAL**

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BlueCross BlueShield of Tennessee
BlueAdvantage
P.O. Box 180205
Chattanooga, TN 37402-7205
Fax: 1-800-255-0244

Home Infusion Therapy Authorization Request Form

MEMBER INFORMATION		
Member Name (First, Middle, Last)	ID Number	Date of Birth
Address (Street, City, State, ZIP)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Insurance Coverage: <input type="checkbox"/> Medicare <input type="checkbox"/> BlueCare <input type="checkbox"/> TennCareSelect <input type="checkbox"/> Other /

Primary Diagnosis: ICD-9 Code:	HIT Related Diagnosis: ICD-9 Code:	Other Diagnosis: ICD-9 Code:
Supportive Documentation Attached: <input type="checkbox"/> Signed Doctor's Orders <input type="checkbox"/> Clinical History <input type="checkbox"/> Culture & Sensitivity <input type="checkbox"/> Misc. Lab	Justification for Therapy	Dates of Service for this Authorization From: _____ To: _____
Daily Administration Schedule for this Infusion Therapy Continuous? <input type="checkbox"/> Yes <input type="checkbox"/> No Pump Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of HIT Therapy <input type="checkbox"/> IV Hydration <input type="checkbox"/> TPN <input type="checkbox"/> Enteral <input type="checkbox"/> IV Drug Administration <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Aerosol <input type="checkbox"/> Other	
Previous Service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reference #:	Date of last service:

J 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	

PHYSICIAN AND SUPPLIER INFORMATION	
Physician Name	BlueCross BlueShield of Tennessee Provider Number
Address (Street, City, State, ZIP)	Telephone Number Fax Number () ()
Infusion Agency Name	BlueCross BlueShield of Tennessee Provider Number
Infusion Agency Address (Street, City, State, ZIP)	Telephone Number Fax Number () ()
Contact Person	Title
Signature X	Date

NOTE: Doctor's orders, clinical information, and appropriate lab results 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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