

DATE: _____

FAX TO: 502-585-8204

ATTN: PASSPORT HEALTH PLAN HOME HEALTH



HOME INFUSION AUTHORIZATION FORM

MEMBER'S NAME _____

PASSPORT ID _____ MEMBER'S DOB _____

AUTHORIZATION NUMBER ____ - ____ - ____

DIAGNOSIS _____ ORDERING MD _____

IF MC PRIME, WHY UNABLE TO BILL MC: _____

NUMBER OF RN VISITS APPROVED _____

DATES OF SERVICE _____

INFUSION THERAPY REQUESTED WITH DATES OF SERVICES REQUESTED

INFUSION THERAPY APPROVED WITH DATES OF SERVICES APPROVED

BRIEF CLINICAL SUMMARY

CURRENT LAB RESULTS

PROVIDER ID _____ CONTACT PERSON _____

REQUESTING AGENCY _____

AGENCY PHONE # _____ FAX # _____

PASSPORT PERSON AUTHORIZING _____

DATE AUTHORIZED _____