IV Therapy Authorization Request Form - Commercial

ConnectiCare, Inc. & Affiliates

Date:	Member ID #:
Member Name:	Member DOB:
Requesting Agency:	Contact Name:
Requesting Provider ID #:	Contact Phone # and Ext:
Tax ID #:	Contact Fax #:
Previous Authorization #, if applicable:	Referring Physician Name:
ICD-9*/ICD-10* Code(s):	

* Services or inpatient discharges prior to Oct. 1, 2015 must use ICD-9 codes; services or inpatient discharges after Oct. 1, 2015 must use ICD-10 codes.

Fax Form with Supporting Medical Documentation to Clinical Review at 1-866-934-5313 or 1-860-409-2437

Date span for requested services _____ to _____

IV Therapy HCPCS/CPT Code	# of Units or Days	Frequency	Total # Requested	Completed by ConnectiCare
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____
				# Approved: _____ Approved by: _____

Supplies:

Supplies HCPCS Code	Amount Requested	Completed by ConnectiCare
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____
		# Approved: _____ Approved by: _____

Fax form and medical documentation to Clinical Review at 1-866-934-5313 or 1-860-409-2437

Please Note:
Services are not considered authorized until ConnectiCare issues an authorization.
Lack of information will delay processing of request.

Please contact Clinical Review at 1-800-562-6833 (select option #4) with any questions about pre-authorization.
This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.

Last reviewed 9/15

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