



PO Box 9201 Austin, TX 78766  
Phone: 800-477-4625  
Fax: 512-904-7544

## INFUSION THERAPY PRE-AUTHORIZATION FORM

\*\*\*Please complete and submit all requested information at least 72 hours prior to date of service\*\*\*

**PROVIDER AND FACILITY MUST BE IN-NETWORK \* For Benefits and Network Status, call Boon-Chapman at 800-252-9653**

Following Must Be Included: Patient’s History & Physical, Clinical/Medical Records pertinent to the request, and Previous Treatment (including medication, therapy with response to treatment, diagnostic testing performed with results)

### Patient Information

Patient Full Name: Male Female  
Patient DOB: Member ID:  
Patient Phone Number: Group Name:

### Ordering Provider Information

Ordering Physician/Provider:  
Tax ID:  
Office Phone Number:  
Office Fax Number:  
Office Contact Person:  
Street Address:  
City:  
State:  
Zip Code:

### Servicing Provider Information

Hospital/Facility/Specialist:  
Tax ID:  
Office Phone Number:  
Office Fax Number:  
Office Contact Person:  
Street Address:  
City:  
State:  
Zip Code:

If there is an adverse determination, would you like a PEER to PEER?

Yes No

Provider Name:  
Phone Number:  
Best Time to Contact:

**Please see second page to complete Infusion Therapy information**

#### Confidential Health Information Enclosed

Health Care Information is personal and sensitive information related to a person’s health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Fax this form to PRIME Dx at 512-904-7544 or Email to [fax@primedx.com](mailto:fax@primedx.com)



## INFUSION THERAPY PRE-AUTHORIZATION FORM (Cont.)

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### Infusion Therapy Information

ICD Code & Diagnosis:  
Date Diagnosed:  
How was diagnosis made:  
Plan of Care:  
Start Date (Date of Service):

Drug/J Code	Dose	Frequency	Duration

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