Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Infusion Service Authorization Request

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•

**** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS ****

Member's primary health insurance: Advanced Health OHP **Dual Eligible - has Medicare and Advanced Health OHP**

Member Name: ____________________________________ Plan ID #: ___________________ DOB: ____/____/____

Requesting Provider: ________________________________ Contact Name: ___________________________________

Phone #: ____ Fax #: ____

Prescribing MD: ____________________________________ Initial Service Renewal

Requested Dates: ____/____/_____ to ____/____/_____ Re-Evaluation Date: ____/____/_____

ICD-10 Code(s):__________ __________ __________ (***Required)** Place of Service (Facility): ____________________________ (***Required)**

Diagnosis: __________________________________ (***Required)**

Type of Service Requested	Prescribed Therapy/Services and Order	J Code & Units Requested
TPN/Parenteral Nutrition		
Chemotherapy		
Pentamidine		
Antivirals		
Antibiotics		
Nursing Services (list codes)		
Equipment (list codes)		

Frequency of Service:

❑ Continuous ❑ Daily Hours/Doses per day: ____

Signature of Requesting Provider: ____ Date: ____/____/____

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare, and Advanced Health as applicable.

(Rev 3/18)