Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Infusion Service Authorization Request

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

****PLEASE NOTE: INCOMPLETE FORMS WILL BE CANCELLED AS INVALID AUTHORIZATION****

Member Name: _____ Plan ID #: _____ DOB: ____/____/____

Requesting Provider: _____ Contact Name: _____

Requesting Provider NPI#: _____ Fax #: _____

Phone #: _____ Initial Service ☐ Renewal ☐

Prescribing MD: _____ Re-Evaluation Date: ____/____/_____

Prescribing MD NPI#: _____ Place of Service (Facility): _____

Requested Dates: ____/____/_____ to ____/____/_____ Place of Service NPI: _____

(*Place of Service and Place of Service NPI are REQUIRED)

ICD-10 Code(s):_____ _____ (***Required)**

Type of Service Requested	Prescribed Therapy/Services and Order	J Code Requested	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.