

UNIVERSAL HOME INFUSION / ENTERAL AUTHORIZATION FORM

S.O.C. Date: ___/___/___	Initial: <input type="checkbox"/>	Reauthorization: ___/___/___	
Vendor Discharge Date: ___/___/___	MD Agrees: Y/N	Patient Agrees: Y/N	

Patient Information

Name: _____
 S.O.C. Address: _____

 Telephone #: _____
 DOB: ___/___/___
 Homebound: Y/N Why? _____
 Diagnosis: _____
 Surgery: N/A _____

MD Information

Ordering MD: _____
 MD Phone#: _____
 PCP: _____
 Date of Next MD Visit: ___/___/___

Health Plan Information

Health Plan Name: _____
 Insurance #: _____
 Health Plan CM: _____
 Initial Auth#: _____
 Telephone #: _____ Fax #: _____

Vendor Information

Vendor Name: _____
 Provider Number: _____
 Contact: _____
 Telephone #: _____ Fax#: _____

Vendor Services

Lab: _____
 Supplies: _____
 Equipment: _____
 Will vendor provide RN?: Y / N
 If no, name of agency?: _____
 RN to bill insurance on their own: Y / N
 RN to bill vendor: Y/N
 If Yes: Negotiated or Contracted Rate _____
 Notes sent with bill: Y/N Date: ___/___/___

Caregiver Information

Name: _____
 Relationship: _____
 Type of Assistance: _____
 Teachable/Not Teachable: _____
 Primary Phone#: _____

Vendor Comments: _____

	Medications	Parenterals	Enterals
Access			
Drug/Solution/Formula			
S code(s)			
Dose			
Frequency			
Duration			
Caloric Value			
Delivery Schedule			
RN Visits			
Start Date			
End Date			
Auth # Visits			
Health Plan Auth #			

Comments: _____

Name: _____ **Title:** _____ **Date:** ___/___/___