Security Health Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Home Infusion – Chemotherapy

Prior Authorization Request

Date ____________________

Member information		
Member name (print)	SMID	Date of birth (month/day/year)

Provider information		
Ordering provider name (print)	Telephone number	Fax number
Place of service: ☐ Home ☐ Skilled nursing facility ☐ Other ____________		
DME name		
Vendor contact name	Vendor telephone number	Vendor fax number
DME vendor address		

Procedure information		
Scheduled date of service or equipment to be received (month/day/year)	Requested service/procedure/DME	HCPC code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Route of administration: ☐ Central line (including PICC) ☐ Hemodialysis access line ☐ Peritoneal catheter ☐ Other ____________________

Days per week administered or infused ____________________

Date of start of care (m/d/y) _____ /_____ /_____ End date (m/d/y) _____ /_____ /_____

Product HCPCS code(s): Code 1 ___________ Code 2 ___________ Code 3 ___________ Code 4 ___________

Chemo agent name ____________________ ☐ Yes ☐ No

Ordering physician's name ____________________

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

______________________________ Provider signature

______________ Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715.221.9918

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Customer Service at 1.800.472.2363.

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