

## Chemotherapy Infusion

### Prior Authorization Request

Date \_\_\_\_\_

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: <input type="checkbox"/> Ambulatory surgery center <input type="checkbox"/> Hospital outpatient <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Provider's office <input type="checkbox"/> Infusion center <input type="checkbox"/> Long term care center <input type="checkbox"/> Member's home <input type="checkbox"/> Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	
NDC code(s)	Dose/strength	
Frequency	Desired length of therapy	
Route: <input type="checkbox"/> IV <input type="checkbox"/> SQ <input type="checkbox"/> Other _____		

Indication/ Diagnosis	Medication Name	Dose and Frequency	Number of Planned Cycles (for Chemo) or Therapy Duration	Current Cycle (if applicable)

**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 715-221-6616

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

**If you have any questions, please contact Customer Service at 1-800-548-1224**