SecurityHealth 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

**IV Infusion**

# Prior Authorization Request

Date _____

| To be completed by home health | | Date (month/day/year) / / |
|---|---|---|
| Patient name (print) | SMID | Date of birth (month/day/year) / / |
| Vendor name | Vendor phone | Vendor fax |
| Ordering physician name | Physician phone | |
| Diagnosis (ICD code) | | |

| Therapy | Code | Drug/Frequency/Dose/ Route of Administration | Begin Date |
|---|---|---|---|
| ☐ Registered nurse | | | |
| ☐ Anti-infective therapy | | | |
| ☐ Hydration therapy | | | |
| ☐ Pain management | | | |
| ☐ Other therapies | | | |
| ☐ Home nursing visits | | | |
| ☐ Catheter care (includes dressing changes) | | | |
| ☐ Other supplies | | | |

**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

  