

Authorization does not guarantee payment, which is affected by other factors, such as eligibility, benefit limitations, exclusions and other coverage issues.

**Unison Health Plan  
Home IV and Homecare Re-authorization Request Form**

**Please fax this form to the ordering physician's office. The physician's office is to fax the reviewed and signed form to Unison to obtain additional authorization.**

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|--|---------------------|
| <input type="checkbox"/> Unison of PA (incl. Adult Basic & Kids) | Fax #: 412-457-1351 |
| <input type="checkbox"/> Unison of DE                            | Fax #: 877-877-8230 |
| <input type="checkbox"/> Unison of OH                            | Fax #: 866-839-6454 |
| <input type="checkbox"/> Unison of SC                            | Fax #: 866-841-9336 |
| <input type="checkbox"/> Unison of TN                            | Fax #: 888-869-3118 |
| <input type="checkbox"/> Unison Advantage                        | Fax #: 866-839-4066 |

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Date \_\_\_\_\_ IV Vendor \_\_\_\_\_ Provider Number \_\_\_\_\_

Phone Number \_\_\_\_\_ Contact Person \_\_\_\_\_

Member Name: \_\_\_\_\_ ID# \_\_\_\_\_

List all that is being requested – IV medication, Skilled Nursing Visits, Home PT/OT/ST:

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Previous Authorization Number \_\_\_\_\_ Diagnosis Code \_\_\_\_\_

Dates(s) of Service Requested: Start Date \_\_\_\_\_ Stop Date \_\_\_\_\_

Ordering MD \_\_\_\_\_ Phone Number \_\_\_\_\_

Frequency of Skilled Nursing Visits or PT/OT/ST \_\_\_\_\_

Support system/Caretaker \_\_\_\_\_

Current IV order (if applicable):

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NDC/J-Code(s): \_\_\_\_\_

Reason member is homebound: \_\_\_\_\_

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Updated clinical information:

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MD signature/Date: \_\_\_\_\_