

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

**Unison Health Plan of Ohio
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 (Attention: UM Department) to obtain additional authorization. (866-839-6454)

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:

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):

NDC/J-Code(s): _____

Reason member is homebound: _____

Updated clinical information:

MD signature/Date: _____