of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

HIT Request Form

BlueCare℠
TennCare*Select*

Member Information:

Patient's Name (First, Middle, Last)	Patient's ID (SS) Number	Patient's Date of Birth
Patient's Address (Street, City, State, ZIP)	Patient's Sex ❑ Male ❑ Female	Primary Insurance Coverage: ❑ Medicare ❑ BlueCare℠ ❑ TennCareSelect℠ ❑ Other

Primary Diagnosis: ICD-10 Code:	**HIT Related Diagnosis:** ICD-10 Code:	**Other Diagnosis:** ICD-10 Code:
Supportive Documentation Attached: ❑ Signed Doctor's Orders ❑ Clinical History ❑ Cutlure & Sensitivity ❑ Misc. Lab	**Justification for Home Infusion Therapy (HIT):**	**Dates of Service for this Reference:** From: _____ To: _____

Daily Administration Schedule for this InfusionTherapy:	**Type of HIT Therapy**
Continuous? ❑ Yes ❑ No Pump Required? ❑ Yes ❑ No	❑ IV Hydration ❑ TPN ❑ Enteral ❑ PO ❑ IV Drug administration ❑ Chemotherapy ❑ Aerosol ❑ Other
Is this patient receiving private duty nursing? ❑ Yes ❑ No	Is this patient receiving any skilled nursing services in addition to home infusion? ❑ Yes ❑ No

Previous Service? ❑ Yes ❑ No Reference # Date of Last Service:

HCPCS*	**Drug/Supplement with Dosage and Frequency** *Code J3490 Requires NDC Number	**Route of Administration**					**Total Units Requested**
		IV	**IM**	**SQ**	**Tube**	**PO**	
Per Diem							
Per Diem							

Physician and Supplier Information:

Physician's Name	BlueCross BlueShield of Tennessee Provider Number	
Physician's Address (Street, City, State, ZIP)	Telephone Number	Fax Number
Infusion Agency's Name	BlueCross BlueShield of Tennessee Provider Number	
Infusion Agency's Address (Street, City, State, ZIP)	Telephone Number	Fax Number
Contact Person	Title	
Signature	Date	

NOTE: Doctor's orders, clinical information, and appropriate lab must be received with the request for service or within two (2) business days of receiving the initial request for service.