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Sentara Health Plans

PO Box 66189
Virginia Beach, VA 23466

Commercial Plans:

Authorization Request for Outpatient Intravenous Therapy

Please submit via the provider portal or
fax to **757-431-7757** or **1-844-668-1550**

Member Name/Last, First	Member ID/Policy#	Date of Birth/Age	Today's Date

The below information and pertinent medical notes are required to process your request:

Site of Administration: _____Infusion Center ☐ MD Office ☐ Home Health ☐

Diagnosis Codes: ____/_____/_____/_____ Diagnosis Description: _____

Provider Information

Full Name of Ordering Physician:_____

Sentara Provider# _____NPI#_____Tax ID#_____

Full Name of Servicing Provider/Facility:_____Phone:_____Fax:_____

Sentara Provider#_____NPI#_____Tax ID#_____

Person Completing Form:_____Phone:_____Fax:_____

Physician's Orders

Start of Care: ___/___ / ___ End of Care: ___/ ___/___

Drug Name / J-Code: _____Dose: _____Frequency: _____
Drug Name / J-Code: _____Dose: _____Frequency: _____
Drug Name / J-Code: _____Dose: _____Frequency: _____

Home Health Per Diem Codes: _____/_____/_____

Comments: _____

_____

_____

*****Specialty medication PA drug form must be submitted with this request if applicable.**
Forms are available at sentarahealthplans.com.