Vaccines Coverage Determination





Date:

	hSpring Coverage Det o Health Coverage Det						HEALTHSP	RING company	
Office Contact:				Provider Specialty:					
Provider First Name:				Provider Last Name:					
Provider Phone:				Provider Fax:					
Provider	Address:						_	_	
License Number:			DEA Number:				NPI Number:		
Member I	Name:								
Member /	Address:								
Member Phone:(H)					(C)				
Member ID:					DOB:				
Rx Prescription Information									
Drug:			Dosage:		Frequency:		Quantity		
□ Brand	□ Generic	□ New Mo	edication	□ Continua	ation (Provid	de Start Date)		Refills:	
List Diagn	osis/ICD-9 code(s):								
For Hepatitis B vaccine, is the individual considered to be at high risk?								No	
(Examples of high risk are: Specify the conditions surrounding the high risk patient.									
				•					
For Hepatitis B vaccine, is the individual considered to be at intermediate risk? Specify the conditions surrounding the high risk patient.							Yes	No	
	Specify the conditions	surrounain	g the nigh n	isk patient.					
Is this request for immediate use?						Yes	No		
Is this request for prophylaxis use?						Yes	No		
Administration Site: Patient's home: Home infusion:							Skilled nursing:		
	·	an's office:		Long Ter	_		_ Other:		
Drug Supplied By: Pharmacy: Physician's supply: Other:									
Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour									
	review time frame ma maximum function.	y seriousl	y jeopardiz	ze the life o	r health of th	ne member or the n	nember's a	bility	

Provider Signature:

^{*}For specialty medications, I authorize HealthSpring as my designated agent to forward the above prescription to the preferred specialty pharmacy