

## Oncology Treatment Plan Prior Authorization Request Form

*Fax to: (316) 928-2539*

SECTION 1: MEMBER INFORMATION	
Member Name	Birth Date (mm/dd/yyyy)
Insurance ID Number	Phone Number

SECTION 2: REQUESTING / ORDERING PROVIDER INFORMATION			
Ordering Provider Name			
Street Address	City	State	Zip
Return to Name	Return to Fax	Telephone Number	

SECTION 3: PLACE OF SERVICE			
<input type="checkbox"/> Inpatient	Anticipated admit Date: _____ Days requested: _____		
<input type="checkbox"/> Outpatient	Anticipated Date of service: _____		
Proposed Facility Name	NPI		
Street Address	City	State	Zip
Tax ID			

SECTION 4: TYPE OF SERVICE	
<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Radiation	
ICD-10 Codes: _____	
CPT Codes: _____	

SECTION 5: PLEASE MAKE SURE THE FOLLOWING INFORMATION IS INCLUDED:
<ul style="list-style-type: none"> <li>Scheduled treatment plan – to include dosing and timing</li> <li>Clinical notes</li> <li>Pathology and lab results</li> <li>Imaging studies</li> </ul> <p style="text-align: center; margin-top: 10px;"><b>***Failure to include the requested information may delay the processing of your request***</b> Please allow 48-72 hours for processing of your request.</p> <p style="font-size: small; margin-top: 10px;">Benefits are subject to all eligibility, plan provisions and limitations in force at the time services are rendered. For benefits and eligibility information, please contact the claims administrator at 866-827-6607. By submitting this form, the provider is hereby agreeing to receive a written notice delivered via facsimile.</p>

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