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

☐ **Inpatient** **Anticipated admit Date:** _____ **Days requested:** _____

☐ **Outpatient** **Anticipated Date of service:** _____

Proposed Facility Name	**NPI**		
Street Address	**City**	**State**	**Zip**
Tax ID			

SECTION 4: TYPE OF SERVICE

☐ **Chemotherapy**

☐ **Radiation**

ICD-10 Codes: _____ _____ _____ _____ _____ _____

CPT Codes: _____ _____ _____ _____ _____ _____

SECTION 5: PLEASE MAKE SURE THE FOLLOWING INFORMATION IS INCLUDED:

- **Scheduled treatment plan – to include dosing and timing**
- **Clinical notes**
- **Pathology and lab results**
- **Imaging studies**

*****Failure to include the requested information may delay the processing of your request*****
Please allow 48-72 hours for processing of your request.

The above services will be considered at the lessor of ASP plus 200% or the Preferred Provider Organization (PPO)/Plan allowance. 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.