



# 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;"><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>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.</p>

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