PO Box 9201 Austin, TX 78766
Phone: 855-266-2093
Fax: 866-502-0297

CHEMOTHERAPY & RADIATION THERAPY PRE-AUTHORIZATION FORM

Please complete and submit all requested information at least 72 hours prior to date of service

PROVIDER AND FACILITY MUST BE IN-NETWORK * For Benefits and Network Status, call Boon-Chapman at 855-516-8531

Following Must Be Included: Patient's History & Physical, Clinical/Medical Records pertinent to the request, and Previous Treatment (including medication, therapy with response to treatment, diagnostic testing performed with results)

Patient Information

Patient Full Name:
Patient DOB:
Patient Phone Number:

Male Female
Member ID:
Group Name:

Ordering Provider Information

Ordering Physician/Provider:
Tax ID:
Office Phone Number:
Office Fax Number:
Office Contact Person:
Street Address:
City:
State:
Zip Code:

Servicing Provider Information

Hospital/Facility/Specialist:
Tax ID:
Office Phone Number:
Office Fax Number:
Office Contact Person:
Street Address:
City:
State:
Zip Code:

If there is an adverse determination, would you like a PEER to PEER?

Yes No
Provider Name:
Phone Number:
Best Time to Contact:

Please see second page to complete Chemotherapy and Radiation Therapy information

Fax this form to Prime Dx at 866-502-0297

CHEMOTHERAPY & RADIATION THERAPY PRE-AUTHORIZATION FORM (Cont.)

Chemotherapy Information

ICD Code & Diagnosis:
Date Diagnosed:
How was diagnosis made:
Staging:
Is the patient going to receive concomitant radiation therapy? Yes No

- If yes, please complete Radiation Information below.

Plan of Care – Please include all Supportive Drugs (anti-nausea, growth factors, erythropoietin, etc.)
Start Date (Date of Service):

Drug/J Code	Dose	Frequency	Duration

Radiation Therapy Information

ICD Code & Diagnosis:
Date Diagnosed:
How was diagnosis made:
Staging:
Is the patient going to receive concomitant chemotherapy? Yes No

- If yes, please complete Chemotherapy Information above.

Plan of Care – Please include all Supportive Drugs (anti-nausea, growth factors, erythropoietin, etc.)
Start Date (Date of Service):
Tumor Location:
Type of Radiation Therapy:

Codes	Frequency	Codes	Frequency

Fax this form to PRIME Dx at 866-502-0297