PO Box 9201 Austin, TX 78766
Phone: 800-477-4625
Fax: 512-904-7544

MONTGOMERY COUNTY HOSPITAL DISTRICT (MCHD) HCAP 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 MCHD at 936-523-5111

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

Confidential Health Information Enclosed

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Fax this form to PRIME Dx at 512-904-7544 or Email to fax@primedx.com

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

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