Outpatient Chemotherapy Chemotherapy Request Form Fax to 833-581-1861 (Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ ☐ Medicare ☐ Commercial

ORDERING/ATTENDING PROVIDER

Name: _____ NPI: _____

Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

SERVICING FACILITY/VENDOR

Name: _____ NPI: _____

Address: _____

Requested Start Date of Service: _____

HCPCS J Code (s): _____ ICD10 Diagnosis Code(s): _____

Please answer the following clinical questions:

What type of cancer does the member have (include histology) and what stage disease?

_____

What is the member's chemotherapy regimen? _____

What line of therapy is this considered (First, Second, Subsequent)? _____

What previous therapies has the member received? (Include if the member progressed or relapsed): _____

_____

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****