Outpatient 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?

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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****

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