

IMRT Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Servicing Provider: _____ **Fax:** _____ **Phone:** _____ **Place of Service:** _____
Diagnosis code: _____ **Procedure codes:** _____ **# of fractions requested** _____

The generally accepted definition of head and neck cancers includes cancers arising in the oral cavity and lip, larynx, hypopharynx, oropharynx, nasopharynx, paranasal sinuses and nasal cavity, salivary glands, and occult primaries in the head and neck region. Cancers generally not considered as head and neck cancers include uveal and choroidal melanoma, cutaneous tumors of the head and neck, esophageal cancer, tracheal cancer, and cancer of the thyroid gland.

1. Is IMRT being prescribed to treat a patient with head and neck cancer?..... Yes No
 Location and cell type: _____
2. Is request for malignant or benign neoplasm of CNS with lesion in close proximity to optic nerve or brain stem? Yes No

Prostate Cancer:

3. Is IMRT being prescribed to treat a patient with prostate cancer who will be receiving definitive dose escalated external beam radiation therapy at prescribed radiation doses of 75 to 80 Gy? Yes No
4. Is the patient s/p prostatectomy with evidence of local recurrence where patient will receive salvage radiation therapy at a prescribed dose of 66 Gy or more to the prostate bed? Yes No
5. Is the patient s/p prostatectomy and at high risk for recurrence due to extracapsular extension, pathologic T3 disease, seminal vesical invasion, positive margins &/or positive nodes, who will receive adjuvant (post-op) radiation therapy at a prescribed dose of at least 66 Gy to the prostate bed &/or pelvis?..... Yes No
6. Will the patient be receiving a combination of radioactive implant treatment and external beam radiotherapy? Yes No

Cancer other than Head / Neck or Prostate:

7. Is IMRT being prescribed for squamous cell cancer of the anus/anal canal? Yes No
8. Is IMRT being prescribed for a cancer **other** than head and neck, anus/anal canal, prostate, or CNS lesion close to optic nerve or brain stem?..... Yes No
9. If question #8 is Yes, please describe what IMRT is being requested for: _____

Effective: 5/1/11

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Please certify the following by signing and dating below:

*Physician signature: _____ Date: _____
 (*Original Physician signature required. Stamped signatures not acceptable)

For BCBSNC members, fax form to 1-800-672-6587
For NC State Health Plan members, fax form to 1-866-225-5258

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