of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Radiation Oncology Request Form

To request services for Commercial fax to 1-866-558-0789.
Requests can be submitted online at any time through **Availity.com.**

Date Submitted: _____ Pages attached (include cover and/or form): _____

Contact Name: _____ Contact Phone #: _____ Contact Fax #: _____

***** Please be sure contact fax number is clear due to HIPAA, since decision letters will be faxed to the provider.***

Member Name:	Member ID Number:
Date of Birth (mm/dd/yyyyy):	☐ Male ☐ Female
Diagnosis (including ICD-9-CM Code):	
If part of a panel or panels – what is the name of the panel(s)?	

Requesting provider information below:

Requesting Provider:	Provider ID #:	NPI #:
Telephone #:	Fax #:	
Address:		
City	State:	ZIP:

Facility:	Facility Provider #:	Facility NPI #:
Facility Telephone:	Facility Fax #:	
Facility Address:		
Facility City:	State:	ZIP:

Requested Code:	**Code description**

Codes continue on next page

Member Name: _____ Date of Birth: _____ Subscriber ID: _____

Requested code (continued):	**Code description**

Clinical questions:

Type of cancer patient being treated for: _____
Does patient have distant metastases (i.e., to brain, lung, liver, bone, etc.) ☐ Yes ☐ No
What is the treatment intent: ☐ Pre op ☐ Definitive ☐ Post op ☐ Palliative ☐ Other
What is the clinical staging for this patient? _____
If this request is regarding Proton Beam Treatment: Is this request being submitted under the Proton Access Act bill for State of Tennessee group members? ☐ Yes ☐ No
Clinical Information Requested Past medical history, provider's orders/treatment plan, IV meds, oxygen support, all pertinent lab values, all pertinent diagnostic testing, wound description and care, nutrition/diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information. Please attach imaging reports if applicable.

By submitting this request, you are confirming that you have provided all clinical information available pertinent to this request and you are requesting the decision be made based on information provided in your submission.

Provider Signature:_____ Date:_____