



Radiation Therapy Treatment Notification Form for Transition Cases

A Radiation Therapy Treatment Notification Form must be completed to notify NIA about patients who began radiation therapy prior to coverage by BlueCross BlueShield of Western New York and for whom treatment is expected to continue and be covered by BlueCross BlueShield of Western New York.

- Important Notes Regarding Notification**
- Providers can send completed forms for each patient to NIA by fax at: 1-800-965-6286.
 - A confirmation notification will be faxed to the provider within 48 hours of receipt.

Note: Preauthorization through NIA may only be required for certain lines of business.

Submitted By	Name (Last, First)		
	Phone #	Fax #	<i>*Required</i>
Member Information	Name (Last, First)		
	Address		
	Gender: <input type="radio"/> M <input type="radio"/> F	DOB	Member ID
Provider Information	Radiation Oncologist Name		
	Address		
	Phone #	Fax #	
	Physician Tax ID		
	Radiation Therapy Facility		
	Address		
	Phone #	Fax #	
	Facility Tax ID		
Radiation Therapy Treatment Plan Information	Diagnosis – ICD		
	Primary Tumor Site Being Treated		
	<input type="radio"/> Breast	<input type="radio"/> Colon	<input type="radio"/> Prostate <input type="radio"/> Rectal
	<input type="radio"/> Lung	<input type="radio"/> Other:	
	Treatment Start Date:	Anticipated End Date:	
	Radiation Therapy Type		
	<input type="radio"/> Low-dose-rate (LDR) Brachytherapy		
	<input type="radio"/> High-dose-rate (HDR) Brachytherapy		
	<input type="radio"/> 2D Conventional Radiation Therapy (2D)		
	<input type="radio"/> 3D Conformal Radiation Therapy (3D-CRT)		
<input type="radio"/> Intensity Modulated Radiation Therapy (IMRT)			
<input type="radio"/> Stereotactic Body Radiation Therapy (SBRT)			
<input type="radio"/> Other:			