



Inpatient Radiation Therapy Notification Form

This form should be completed if your patient began radiation therapy as an inpatient and continued treatment as an outpatient. Subsequent outpatient radiation therapy will not require a preauthorization medical necessity review.

Important Notes Regarding Notification

- Providers can send completed forms for each patient to NIA by fax at: 800-965-6286.
- Complete the form as soon as possible after treatment begins to avoid any delays in payment for services rendered for these patients.
- A confirmation notification will be faxed to the provider within 48 hours of receipt.

Submitted By	Name <i>(Last, First)</i>			
	Phone #	Fax #	<i>*Required</i>	
Member Information	Name <i>(Last, First)</i>			
	Address			
	Gender: <input type="radio"/> M <input type="radio"/> F	DOB	Member ID	
Provider Information	Radiation Oncologist Name			
	Address			
	Phone #	Fax #		
	Physician Tax ID			
	Outpatient 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		<i>Estimated Remaining Outpatient Treatments</i>	
	<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:				