

Radiation Therapy Treatment Notification Form for Transition Cases



Complete this Radiation Therapy Treatment Notification Form to notify Highmark Blue Cross Blue Shield of Western New York about radiation treatment impacted by one of the following scenarios (*select one*):

- Patient began radiation therapy prior to coverage by Highmark Blue Cross Blue Shield of Western New York
- Patient began radiation therapy while in an inpatient setting and treatment is expected to continue on an outpatient basis

Providers can send completed forms for each patient to NIA by fax at: 888-656-1321.

Submitted By	Name (<i>Last, First</i>)		
	Date:	Phone #	Fax # *Required
Member Information	Name (<i>Last, First</i>)		
	Address		
	Gender <input type="checkbox"/> M <input type="checkbox"/> 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		
	Site/Condition Treated <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Lung <input type="checkbox"/> Metastasis <input type="checkbox"/> Prostate <input type="checkbox"/> Rectal <input type="checkbox"/> Other:		
	Treatment Start Date		Treatment End Date
	Radiation Therapy Type		CPT code
	<input type="checkbox"/> Low-dose-rate (LDR) Brachytherapy		# of Treatments
	<input type="checkbox"/> High-dose-rate (HDR) Brachytherapy		
	<input type="checkbox"/> 2D Conventional Radiation Therapy (2D)		
	<input type="checkbox"/> 3D Conformal Radiation Therapy (3D-CRT)		
	<input type="checkbox"/> Intensity Modulated Radiation Therapy (IMRT)		
	<input type="checkbox"/> Stereotactic Body Radiation Therapy (SBRT)		
<input type="checkbox"/> Proton Beam Therapy			
<input type="checkbox"/> Other:			
Treatment Plan Update	A new treatment notification form must be submitted if there is a change to CPT codes, # of treatments and/or treatment end date. <input type="checkbox"/> Check here if this form is to report changes to a previously submitted form. <i>Complete all fields above. For Treatment End Date, enter NEW end date, if applicable. For CPT code, enter all CPT codes (including codes previously reported). For # of treatments, indicate total # of treatments needed (including # previously reported).</i>		