Radiation Therapy Treatment Notification Form for Transition Cases

HIGHMARK. NORTHEASTERN NEW YORK
An Independent Licensee of the Blue Cross Blue Shield Association

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

☐ Patient began radiation therapy prior to coverage by Highmark Blue Shield of Northeastern 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 *Date:*	Name *(Last, First)*		
	Phone #	Fax #	*Required
Member Information	Name *(Last, First)*		
	Address		
	Gender ☐ M ☐ 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 ☐ Breast ☐ Colon ☐ Lung ☐ Metastasis ☐ Prostate ☐ Rectal ☐ Other:		
	Treatment Start Date	Treatment End Date	
	Radiation Therapy Type	**CPT code**	**# of Treatments**
	☐ Low-dose-rate (LDR) Brachytherapy		
	☐ High-dose-rate (HDR) Brachytherapy		
	☐ 2D Conventional Radiation Therapy (2D)		
	☐ 3D Conformal Radiation Therapy (3D-CRT)		
	☐ Intensity Modulated Radiation Therapy (IMRT)		
	☐ Stereotactic Body Radiation Therapy (SBRT)		
	☐ Proton Beam Therapy		
	☐ 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. ☐ Check here if this form is to report changes to a previously submitted form. *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).*		