BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

evolent

Radiation Therapy Treatment Notification Form for Transition Cases

Complete this Radiation Therapy Treatment Notification Form to notify BlueCross BlueShield of South Carolina or BlueChoice HealthPlan about radiation treatment impacted by one of these scenarios (select one):

☐ 1. Patient began radiation therapy prior to coverage by BlueCross BlueShield of South Carolina or BlueChoice.

- Providers can fax the completed form to Evolent at 888-656-1321

☐ 2. Patient was simulated or 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 BlueCross BlueShield of South Carolina or BlueChoice by fax at: 803-264-0258
- Confirmation notification will be faxed to the provider within 48 hours of receipt

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's 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: ☐ Breast ☐ Colon ☐ Prostate ☐ Rectal ☐ Lung ☐ Other:		
	Treatment Start Date: BlueCross BlueShield or BlueChoice Coverage 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:		
	☐ Ancillary CPT Codes		
	☐ Ancillary CPT Codes		
Treatment Plan Update	Submit a new treatment notification form 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. 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).*		