



Radiation Therapy Treatment Notification Form for Transition Cases

Complete this form to notify ConnectiCare about radiation treatment impacted by one of the following scenarios (select one):

- Patient began radiation therapy prior to coverage by ConnectiCare
- Patient began radiation therapy while in an inpatient setting and treatment is expected to continue on an outpatient basis

Providers must email completed form for each patient to ConnectiCare at preauthorization@connecticare.com with the subject: Radiation Therapy Treatment for Transition Cases.

Submitted By:	Name (Last, First)		Date
	Phone #	Fax # (required)	
Member Information	Name (Last, First)		
	Address		
	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	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 Being Treated:		
	<input type="checkbox"/> Breast <input type="checkbox"/> Head/Neck <input type="checkbox"/> Colon <input type="checkbox"/> Bone Mets <input type="checkbox"/> Prostate <input type="checkbox"/> Brain/CNS <input type="checkbox"/> Rectal <input type="checkbox"/> Lung <input type="checkbox"/> Other:		
	Treatment Start Date		Treatment End Date
	Radiation Therapy Type	CPT code	# of Treatments
	<input type="checkbox"/> Low-dose-rate (LDR) Brachytherapy		
	<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	<p>A new treatment notification form must be submitted if there is a change to CPT codes, # of treatments and/or treatment end date.</p> <p><input type="checkbox"/> Check here if this form is to report changes to a previously submitted form.</p> <p><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 number of treatments needed (including # previously reported).</i></p>		