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Fax Back Form for
Radiation Oncology Services

(IMRT, Proton, SRS, SBRT, Brachytherapy, and Conventional 3D)

For pre service authorization, please fax this form back to fax# 844-807-8997.

For post service claim review, please fax this form back to fax# 855-808-8601.

Any high-quality color images such as DVHs should be **securely** emailed to PART-CISD@blueshieldca.com
Please include the patient's name and date of birth

BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005

Use **AuthAccel** - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests.
Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

If you received a paper copy of this form and you prefer to answer electronically, please scan this code:

We are sending you this form in response to a health reimbursement claim or prior authorization (PA) request we recently received from you. Below is a list of the pertinent information needed for processing the claim/prior authorization request:

Patient Information	
Subscriber Number	
Patient Account Number	
Full Name	
Date of Birth	
Primary Diagnosis	
*This claim# (or PA req. #):	

Provider Information			
Professional		**Facility (if applicable)**	
Name		Name	
Address		Address	
Phone No.		Phone No.	
Fax No.		Fax No.	
NPI		NPI	
Office Contact Person		Office Contact Person	

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Please note that we request that claims for all **related services** be sent to us as a (complete) **single claim** after the entire course of treatment is ended, including planned boost treatments. *Related services* in this context mean all radiation oncology services of a single patient, by a single healthcare team, for a particular primary diagnosis. Coverage is often dependent on the combination of service codes (CPT/HCPCS) or the number of units of a service that are claimed and documented. Completion of this form as a **single claim** noting all the units provided will help to ensure accurate and timely payment. This form needs to be filled out for each claim submitted, and if more than one claim is submitted it may result in errors or delays due to billing guidelines. Partial submissions will therefore usually result in a request for more information (LOI or Lack of Information letter) to ensure accurate processing. Given our recommendation, please select how you wish to proceed:

☐ **Option A**: We wish to withdraw the processing of *this partial claim. We will instead submit a **single claim** that includes either the full course of treatment or all remaining treatments (if some have already been submitted) at a later time. Related claims that were previously submitted to Blue Shield of California will not be canceled due to the withdrawal request of *this claim.

☐ **Option B**: Please proceed to process *this claim.

- ◯ This is a **partial claim** (representing only a portion of the radiation oncology services rendered by this provider for this course of treatment). Note that coding errors can occur when submitted with multiple partial claims and requests for additional information are common as a result
- ◯ This is a **complete claim** (representing all radiation oncology services rendered by this provider for this course of treatment)

☐ **Option C**: We want to obtain prior authorization (for IMRT or Proton only; DVHs are usually required, see bottom for details). Note that at this time prior authorization is only required for the type of therapy. 3D-CRT, brachytherapy and SRS/SBRT do not require prior authorization. All claims will be reviewed post service for individual CPT codes and number of units, but reviews will be made when requested for all codes submitted for prior authorization.

- ☐ IMRT
- ☐ Proton

Signature: _____ DATE: _____

Authorized representative name: _____

If you chose option A, please only sign the first page of this document and return it to us (fax number located at the top of the first page). There is no need to fill in the bottom portion for now.

If you chose option B, please continue to fill in the rest of this document (pages 1-8) and return it to us (fax number located at the top of the first page).

If you chose option C, please sign the first page of this document and return it to us (fax number located at the top of the first page) along with color DVHs when required. There is no requirement to fill in the bottom portion completely for prior authorization. What will typically be covered without additional documentation is noted in the table below. The entire form will need to be completed post service at the time of submitting a claim.

Please note the type and location of the cancer being treated

- Type of cancer: _____
- Location of cancer:_____
- ICD 10 Primary Diagnosis Code: _____

Please indicate the type of radiation therapy being requested or provided (check all that apply):

- ☐ Three-dimensional conformal radiation therapy (3D CRT)
- ☐ Intensity-modulated radiation therapy (IMRT)
- ☐ Intraoperative radiotherapy (IORT); for rectal cancer only
- ☐ Proton

- ☐ Brachytherapy
  - ☐ High-dose rate (HDR)
  - ☐ Low-dose rate (LDR)
  - ☐ Boost (separate from External Beam Radiation Therapy, or other claim)
- ☐ Stereotactic radiosurgery (SRS)
- ☐ Stereotactic body radiation therapy (SBRT)

This fax back form does not address the following radiation therapy treatments:
- Electronic Brachytherapy

Please indicate if this request is related to professional fees only, facility only or both
(please include modifiers -26 or -TC as appropriate in the form below)

- ○ Professional only
- ○ Facility only
- ○ Both Professional and Facility

Site of Service

- ○ Hospital inpatient
- ○ Hospital outpatient
- ○ Freestanding facility

Background:
The information below indicates what is typically approved for various types of radiation therapy and what requires additional documentation. If additional units are requested beyond the *maximum allowable per standard course of treatment*, the reason for the need for those units must be clearly documented in the medical record, preferably in a separate note.

No prior authorization is needed for 3D CRT, brachytherapy or SRS/SBRT. At this time, only IMRT and proton cases need to have prior authorization for using that approach rather than 3D CRT. Specific codes and numbers of units will be reviewed post-service since the treatment may change during the course of therapy. However, the codes and the typical number of units that would be allowed without additional documentation are noted below.

Blue Shield of California reserves the right to review all claims, including the medical records submitted to verify the submitted form and physician statement of medical necessity.

Related Radiation Oncology Services Performed that apply to this claim

For internal use only, EPS number: _____

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
Clinical Treatment Planning ☐ 77261 ☐ 77262 ☐ 77263		3D CRT = 1* IMRT = 1* IORT = 1* Proton = 1* Brachy = 1* SRS = 1* (77263 only) SBRT = 1* (77263 only)			

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
Simulation ☐ 77280 ☐ 77285 ☐ 77290 *Extra unit allowed for external beam boost on different DOS only*		**Using 3D CRT plan (77295):** 3D = 1*: +1 boost IMRT = 0 IORT = 1* Proton = 1* (77290 only) +1 boost Brachy HDR = 5* SRS/SBRT = 1* **Using IMRT plan (77301):** 3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy HDR = 0 SRS/SBRT = 0			
Verification Simulation ☐ 77280 *Extra unit allowed for external beam boost on different DOS only*		**Using 3D CRT plan (77295):** 3D CRT = 1* IMRT = 0 IORT = 1 Proton = 1* Brachy HDR = 5* 3D CRT EBRT Boost = +1* SRS/SBRT = 1* **Using IMRT plan (77301):** 3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy HDR = 0 3D CRT EBRT Boost = 0 SRS/SBRT = 0			
Respiratory Motion Management ☐ 77293		1 for breast, lung, and upper abdominal cancer (thoracic areas) Otherwise: 3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 0* SRS = 0* SBRT = 0*			
3D CRT Plan ☐ 77295 *Not allowed along with 77301*		3D CRT = 1* IMRT = 0 IORT = 0 Proton = 1* Brachy = 1 per insertion, max 5* SRS/SBRT = 1*			
Basic Dosimetry Calculation ☐ 77300 *Extra unit allowed for external beam boost*		0 if billed with 77306, 77307, 77321, 0394T or 0395T 3D CRT = 4*; +1 boost IMRT = 4*; +1 boost IORT = 4*; + 1 boost Proton = 4*; +1 boost Brachy = 0			

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
		SRS = 4* SBRT = 4*			
IMRT Plan ☐ 77301 *Not allowed along with 77295*		3D CRT = 0 (use 77295) IMRT = 1* IORT = 0 Proton = 1* Brachy = 0 (use 77316, 77317, 77318, or 77295) SRS = 1* SBRT = 1*			
Teletherapy Isodose Plan ☐ 77306 ☐ 77307		1* for mid-Tx change in volume/contour **Using 3D CRT plan (77295):** 3D CRT = 0 IORT = 0 Proton = 0 SRS/SBRT = 0 Brachy = 0 **Using IMRT plan (77301):** IMRT = 0 IORT = 1 Proton = 0 SRS/SBRT = 0			
Brachytherapy Isodose Plan ☐ 77316 ☐ 77317 ☐ 77318 *Can use 77295 instead but not together*		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 1 per insertion, max 5 (cannot be billed in addition to 77295) SRS = 0 SBRT = 0			
Special Teletherapy Port Plan ☐ 77321 *Mainly for electron plans, not to be used with 77306/77307, 77295 or 77301; needs documentation for review*		**Using 3D CRT plan (77295):** 3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 0* SRS = 0* SBRT = 0* **Using IMRT plan (77301):** 3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 0* SRS = 0* SBRT = 0*			
Special Dosimetry Calculation ☐ 77331 *Needs documentation for review*		3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 0*			

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
		SRS = 0* SBRT = 0*			
Treatment Devices, Designs and Construction ☐ 77332 ☐ 77333 ☐ 77334 *Note number of units for each CPT code requested*		**If Billed w/ MLC (77338):** 3D CRT = 1* IMRT = 1* IORT = 0* Proton = 1* Brachy = 0 SRS = 1* SBRT = 1* **Without MLC (any combination of…):** 3D CRT = 5* IMRT = 5* IORT = 0 Proton = 5* Brachy = 0 SRS = 5* SBRT = 5*			
Continuing Medical Physics Consultation ☐ 77336		3D CRT = 8 IMRT = 8 IORT = 0 Proton = 8 Brachy = 0 SRS = 0 SBRT = 0 (1 for every 5 radiation therapy delivery sessions)			
Multi-leaf Collimater (MLC) ☐ 77338		3D CRT = 1* IMRT = 1* if using 77385/77386 for delivery. IMRT = 0 if using G6015/G6016 delivery IORT = 0 Proton = 1* Brachy = 0 SRS = 1* SBRT = 1*			
Special Rad. *Physics* Consult ☐ 77370 *Needs documentation for review*		3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 0* SRS = 0* SBRT = 0*			
SRS Delivery, Cobalt 60 ☐ 77371 *1 or more lesions, one session only*		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 1*, 0 with 77372 or 77373 SBRT = 0			

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
SRS Delivery, LINAC ☐ 77372 *1 or more lesions, one session only*		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 1*, 0 with 77371 or 77373 SBRT = 0			
SBRT Delivery ☐ 77373 *1 or more lesions, per session up to 5*		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 0 SBRT = 5* (one for each session planned, max 5)			
IMRT Delivery ☐ 77385 ☐ 77386 **Outpatient-freestanding:** ☐ G6015 ☐ G6016 (compensator)		3D CRT = 0 IMRT = 28* for prostate cancer; 16* for breast cancer without boost; 24 for breast cancer with boost; no limits otherwise IORT = 0 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
3D CRT Delivery ☐ 77402 ☐ 77407 ☐ 77412 ☐ G6003 ☐ G6004 ☐ G6005 ☐ G6006 ☐ G6007 ☐ G6008 ☐ G6009 ☐ G6010 ☐ G6011 ☐ G6012 ☐ G6013 ☐ G6014		3D CRT = 16* for breast cancer without boost; 24 for breast cancer with boost; no limits otherwise IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
Intraoperative Radiation Treatment Delivery, x-ray, single treatment session ☐ 77424 *For rectal cancer only*		3D CRT = 0 IMRT = 0 IORT = 1 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
Intraoperative Radiation Treatment Delivery, electrons, single treatment session ☐ 77425 *For rectal cancer only*		3D CRT = 0 IMRT = 0 IORT = 1 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
Radiation Treatment Management ☐ 77427		3D CRT = 8 (1 for every 5 RT delivery sessions) IMRT = 8 (1 for every 5 RT delivery sessions) IORT = 0 Proton = 8 (1 for every 5 RT delivery sessions) Brachy = 0			

Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
		SRS = 0 SBRT = 0			
SRS Treatment Management ☐ 77432		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 1* SBRT = 0			
SBRT Treatment Management ☐ 77435		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 0 SRS = 0 SBRT = 1			
Intraoperative Radiation Treatment Management ☐ 77469 *For rectal cancer only*		3D CRT = 0 IMRT = 0 IORT = 1 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
Special MD Consultation (Special Tx Procedure) ☐ 77470 *Needs documentation for review*		3D CRT = 0* IMRT = 0* IORT = 0* Proton = 0* Brachy = 1* SRS = 0* SBRT = 0*			
Proton Delivery ☐ 77520 (non-compensator) ☐ 77522 (compensator) ☐ 77523 (compensator) ☐ 77525 (compensator)		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 28* for prostate cancer; no limits otherwise Brachy = 0 SRS = 0 SBRT = 0			
Application of Radiation Sources: LDR Brachytherapy ☐ 77761 ☐ 77762 ☐ 77763 ☐ 77778		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 1 SRS = 0 SBRT = 0			
Application of Radiation Sources: HDR Brachytherapy ☐ 77770 ☐ 77771 ☐ 77772		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 4 SRS = 0 SBRT = 0			

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Service Code	Modifier	Maximum allowable	# Units Already Paid	# Units Billed	DOS/Date Range
(Please check the box provided for performed services. Usually, only one of the code choices should be checked when there are more than one on a single line/box except Treatment Devices)	(If applicable, particularly -26 or -TC)	Per standard course of treatment** – see BSC8.06 Radiation Oncology	From previous claims (if applicable)	Number of Unit(s) being claimed or requested per CPT/HCPCS for reimbursement with this submission	(Please use the mm/dd/yyyy format. A date range on the first line only is acceptable if the submission is for the entire course of treatment.)
Supervision, Handling, Loading of Radiation Source ☐ 77790		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 1 SRS = 0 SBRT = 0			
High Dose Rate Electronic Brachytherapy, per fraction ☐ 0394T *(skin, melanoma only)* ☐ 0395T *(intracavitary such as IORT)*		3D CRT = 0 IMRT = 0 IORT = 1 Proton = 0 Brachy = 0 SRS = 0 SBRT = 0			
Placement of Radiotherapy Afterloading Catheters ☐ 19296 ☐ 19297 ☐ 19298		3D CRT = 0 IMRT = 0 IORT = 0 Proton = 0 Brachy = 1 SRS = 0 SBRT = 0			
☐ *(other)*					
☐ *(other)*					
☐ *(other)*					

3D CRT: Three-dimensional conformal radiation therapy; IMRT: Intensity-modulated radiation therapy; Proton: Proton beam radiation therapy; Brachy: Brachytherapy; HDR: High-dose rate; SRS: Stereotactic radiosurgery; SBRT: Stereotactic body radiation therapy; EBRT: External beam radiation therapy; TX: Treatment

*More than the maximum per standard course of treatment may be considered medically necessary but requires medical record support for additional units.

The **maximum per standard course of treatment column represents what is allowed under typical circumstances. Many of the services allow for additional units per course of treatment but require the need for those extra units be supported in the medical records submitted. No additional documentation is needed if the number of units claimed does not exceed the standard allowance.

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Please fax the medical records requested and completed form as applicable to Fax# 855-808-8601.

Medical Records (ALL REQUESTS)
☐ History and physical and/or consultation notes including: ☐ Clinical findings (i.e., pertinent symptoms and duration) ☐ Comorbidities ☐ Reason for treatment including type and location of tumor ☐ Pertinent past procedural and surgical history including prior radiation therapy ☐ Documentation of the need for additional units beyond the standard number allowed (CPT/HCPCS)_____ ☐ Color Dose Volume Histograms (DVHs) comparing 3-D to IMRT or IMRT to Proton, when applicable (for most IMRT/proton cases if not already sent and prior authorized). DVHs are NOT needed when using 3D or the following types of IMRT/Proton cases only: o IMRT Prostate o IMRT Head (other than brain) and neck (other than thyroid) o IMRT or Proton Pediatric CNS tumors o IMRT anus or anal canal o Conventional 3-D only cases (no IMRT or Proton requested) ☐ Treatment plan or summary including any brachytherapy, total dose and total fractions/# of treatments ☐ Results/reports of other relevant tests performed ☐ Procedure report(s) as applicable Any high-quality color images should be securely emailed to PART-CISD@blueshieldca.com. In the email to PART-CISD@blueshieldca.com, please include the patient's name, date of birth, member ID, and reference number (if available).

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

If you have any questions or require assistance in completing this form, please contact a Blue Shield Provider Liaison at 800-258-3091. Additional information is available at **blueshieldca.com/provider.**