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Prior Authorization Request Form	Radiation Oncology Services
Standard Fax#: (844) 807-8997	**Urgent Fax#:** (844) 807-8996

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.

☐ New Standard Request ☐ New Urgent Request

Important For Urgent Requests:
Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee.
If there is no MD signature present the request will be processed as a Standard request.

MD Signature REQUIRED For Urgent Requests Only:

☐ Modification, or ☐ Extension Request – Please complete the section below:

Date Last Authorized:	Previous Authorization #
Justification for Modification or Extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Provider Information (Professional):

Name:			NPI:	
Address:				
City:	State:	Zip:	Phone#:	Fax#:
Contact name and phone#:				

Provider Information (Facility - if applicable):

Name:		Tax ID#:		NPI:
Address:				
City:	State:	Zip:	Phone#:	Fax#:
Contact Name/Phone#:				

Anticipated Date of Service:

Place of Service: ☐ Hospital – Inpatient ☐ Hospital - Outpatient ☐ Freestanding Facility

For questions: Call BSC Medical Care Solutions	Phone Number: 1-800-541-6652

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Clinical Information

Type and Location of Cancer:	
Where in the body is radiation being given?	
Type of Service:	☐ Curative ☐ Palliative

Radiation Therapy (requested or provided):

☐Three-dimensional conformal radiation therapy (3D CRT) ☐Intensity-modulated radiation therapy (IMRT) ☐Intraoperative radiotherapy (IORT) – for rectal cancer only ☐Stereotactic radiosurgery (SRS) ☐Stereotactic body radiation therapy (SBRT) ☐Proton	☐ Brachytherapy ☐ High-dose rate (HDR) ☐ Low-dose rate (LDR) ☐ Boost (separate from External Beam Radiation Therapy, or another claim)

Coding Questions? The following link indicates what is typically approved for various types of radiation therapy and what requires additional documentation https://www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/provider/StreamDocumentServlet?fileName=PRV_Radiation_Oncology.pdf.

Requesting additional units? Please indicate the rationale below:

Please provide the Radiation Oncologist consultation notes including:

- ☐ **Past radiation treatment and any relevant findings**.
- ☐ Treatment plan including total fractions/# of treatments.
- ☐ Reason for type of radiation treatment including type (e.g., IMRT) and location of tumor (e.g., bone metastases from breast cancer).
- ☐ Stage of cancer
- ☐ Color Dose Volume Histograms (DVHs) comparing 3D-CRT to IMRT; or 3D-CRT & IMRT to Proton, when applicable (for most IMRT/proton cases if not already sent and prior authorized). DVHs are NOT needed when using 3D-CRT or the following types of IMRT cases only:
  - ☐ IMRT Prostate
  - ☐ IMRT Head (other than brain) and neck (other than thyroid)
  - ☐ IMRT or Proton Pediatric CNS tumors
  - ☐ IMRT anus or anal canal
  - ☐ Conventional 3D-CRT only cases (no IMRT or Proton requested)
- ☐ Results/reports of other relevant tests performed; procedure report(s) as applicable.
- ☐ High-quality color images (e.g., DVHs) – Faxing will **NOT** provide the color details needed. Submit via secure email to PART-CISD@blueshieldca.com. Please include the patient's name, date of birth, member ID, and reference number (if available).

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