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Post-Service Fax Form
Radiation Oncology Services
(IMRT, Proton, SRS, SBRT, Brachytherapy, and Conventional 3D – including IGRT when applicable)

Fax#: (855) 808-8601	**Address:** BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005

Please submit color copies of dose volume histograms (DVHs) for both 3D-conformal radiation therapy (3D-CRT) AND intensity modulated radiation therapy (IMRT) plans via the Provider Connection portal: blueshieldca.com/provider/attach-claimdocs.

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

Date of Service:

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

NOTE: This fax back form does not address Electronic Brachytherapy.

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Please choose one of the options below:

☐ Option A: Pre-service authorization was obtained.

☐ No changes

Services rendered match the Pre-service authorization. No requirement to fill out this form.

☐ With changes

Services rendered are different from the Pre-service authorization. No requirement to fill out this form but please note the changes (either on this form or not), and fax along with medical records supporting the change(s) to fax# 855-808-8601.

☐ Option B: Pre-service authorization was NOT obtained.

☐ Withdraw

Withdraw the processing of this claim. The provider will submit a single claim that includes either the full course of treatment or all remaining treatments (if some were already submitted) later. Related claims that were previously submitted will not be canceled due to the withdrawal request of this claim. No need to fill out this form.

☐ Continue processing – Partial Claim

The claim represents a portion of the radiation oncology services rendered by this provider for this course of treatment. Please fill out the form below or provide the same information, and fax along with medical records to fax# 855-808-8601. **NOTE**: Coding errors and requests for additional information may occur when submitting multiple partial claims.

☐ Continue processing – Complete Claim

The claim represents ALL radiation oncology services rendered by this provider for this course of treatment. Please fill out the form below or provide the same information, and fax along with medical records to fax# 855-808-8601.

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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 the Provider Connection Portal: blueshieldca.com/provider/attach-claimdocs.