

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):

- Patient began radiation therapy prior to the program start of January 1, 2015
- Patient began radiation therapy prior to coverage by BlueCross or BlueChoice®
- Patient began radiation therapy while in an inpatient setting and treatment is expected to continue on an outpatient basis

**Important Notes
About Notification**

- Providers can send completed forms for each patient to BlueCross by fax at: 803-264-0258.
- A confirmation notification will be faxed to the provider within 48 hours of receipt.

Submitted By	Name (Last, First):				
	Date:	Phone:	Fax: *Required		
Member Information	Name (Last, First):				
	Address:				
	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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	<input type="checkbox"/> Breast	<input type="checkbox"/> Colon	<input type="checkbox"/> Prostate	<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	Submit a new treatment notification form if there is a change to CPT codes, # of treatments and/or treatment end date.				
	<input type="checkbox"/> Check here if this form is to report changes to a previously submitted form. <i>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).</i>				