CHEMOTHERAPY OR RADIATION THERAPY PRE-AUTHORIZATION FORM

BMC HealthNet Plan • Two Copley Place • Suite 600 • Boston, MA 02116
Phone: 1-888-566-0008 Fax: 617-748-6080 or 617-748-6155

Fax this form and all pertinent clinical information to request pre-authorization of these services.

Sender Name: ____

Sender Phone #: _______________ **Fax #:** _______________ **E-mail:** _______________

Patient-Member Name: ________________________ **Member ID/SS#:** _______________

DOB: _____/_____/_____ **Sex:** _____ **Other Insurance #:**____________________________

Request by PCP: YES___ NO___

Request by Specialist: YES___ NO___ Specialist Name: ___________________________

Primary Care Site: ____

Attending Physician: ______________________________ **Phone #** __________________

Location of Therapy (choose one): office___ hospital-outpatient___ freestanding clinic____

Primary Diagnosis: ____________________________ **ICD-9 Code:** _________________

Secondary Diagnosis: __________________________ **ICD-9 Code:** __________________

CHEMOTHERAPY:
Medication being administered:____

Number of treatments: ____________ Start Date:______________ End Date:_______________

RADIATION THERAPY:
Area being irradiated:____________________ Start Date: __________ End Date:___________

FOR INTERNAL USE:
Authorization Number: __________Number Visits Approved:____ Expiration Date:___________

The number you will receive from the Prior Authorization Department is a reference number. It is not a guarantee of payment. Actual payment is based upon verification of medical necessity, verification that the service is a covered benefit, and eligibility of the member on the date of service. Submitting cost and pricing information on an authorization request does not guarantee payment at these rates. The Plan reimburses providers based on MassHealth rates unless otherwise specified in their agreement with the Plan.