**Chemotherapy Information Form**

\*\*Please Complete & Submit all requested information at least 72 hours prior to date of Service\*\*

PROVIDER & FACILITY MUST BE IN NETWORK

For Benefits and Network Status call Boon-Chapman at 800-252-9653

Include the Following: Patient's History & Physical, Patients Clinic Records/Medical records pertinent to the request, Previous Treatment (including meds, therapy & response to treatment, pathology, diagnostic testing performed including the results).

**Patient Name:  Date of Birth: **

**Group:  Male** [ ] **/Female**[ ]  **Patient Phone Number: **

**Ordering Physician **

**Contact Person  Tax ID **

**Address  Phone **

**Address  Fax **

**If there is an adverse determination would you like a PEER to PEER? Yes**[ ]  **No**[ ]

**Provider Name: **

**Phone:  Best Time to Contact: **

**Hospital/Facility/Specialist **

**Providing Services: **

**Contact Person  Tax ID: **

**Address  Phone: **

**Address  Fax: **

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**ICD and Diagnosis: **

**Date Diagnosed: **

**How was this Diagnosis made? **

**Staging: **

**Plan of Care: Please indicate if patient is to receive concomitant radiation therapy. Complete Radiation Information Form.**

 

**Chemotherapy Plan of Care: Please include all Supportive Drugs (anti-nausea, growth factors, erythropoietin, etc.)**

**Start Date (Date of Services): **

|  |  |  |  |
| --- | --- | --- | --- |
| Drug/ Jcode | Dose | Frequency | Duration |
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