

Treatment Request Form Radiation Oncology

DIPLOMAT® 



Phone: 888.515.1357

Fax: 844.262.8479

Today's Date: _____

Estimated Date of Service: _____

Patient Information			Physician Information		
Name:			Name:		
DOB:	Gender:		NPI:	DEA:	
Address:			Practice Name:		
City:	State:	ZIP:	City:	State:	ZIP:
Phone:	Alt. Phone:		Phone:	Fax:	
			Office Contact:		
Medical History			Treatment Setting		
Primary Dx and Description (ICD-10):			<input type="checkbox"/> Curative		<input type="checkbox"/> Palliative
Secondary Dx and Description (ICD-10):			If Curative: <input type="checkbox"/> Neo/Adjuvant Radiation <input type="checkbox"/> Definitive		
Current Stage of Cancer:			Concurrent Chemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Area(s) Targeted for Therapy:			Planned Dose in Gy:		
Please specify, if applicable: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral			Planned Dose in Number of Fractions:		
Has/have the affected area(s) previously received radiation therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Treatment Modality (choose one)		CPT		Number of Units	
<input type="checkbox"/> IMRT or VMAT Technique		<input type="checkbox"/> G6015 / G6016 / 77385 / 77386			
<input type="checkbox"/> SBRT or SRS Technique		<input type="checkbox"/> 77371 / 77372 <input type="checkbox"/> 77373 <input type="checkbox"/> G0339 <input type="checkbox"/> G0340			
<input type="checkbox"/> 3D Conformal Technique		Please submit list of requested CPT codes and associated number of units.			
<input type="checkbox"/> Proton Beam					
<input type="checkbox"/> Brachytherapy					
<input type="checkbox"/> Unsealed Source / Radioisotope / Radioembolization					
<input type="checkbox"/> Other (specify):					
If CPT 77370 special medical physics consultation is being requested, please state why:		If CPT 77470 special treatment procedure is being requested, please state why:			

*Reimbursement for CPT codes that support or are integral to the delivery radiation therapy, including clinical treatment planning (77261-77263), simulation (77280-77290, 77293), medical radiation physics and dosimetry (77300, 77301, 77295, 77331, 77306-77307, 77321, 77332-77334, 77336), port films (77417), image guidance (77014, 77387, G6001, G6002, G6017), and radiation treatment management (77427, 77431, 77435), will be subjected to coding rules and medical documentation at the time of claim.

Physician Signature (required to validate request): _____

This form must be completed in its entirety, as it may be forwarded to the health plan for authorization. This facsimile transmission is intended to be delivered to the named addressee and may contain information that is confidential, privileged, and proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and/or telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. DSP-220739-1018