HIGHMARK WESTERN NEW YORK

Outpatient Chemotherapy Chemotherapy Request Form Fax to 833-619-5745 (Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____

J Code (s): _____

Diagnosis Code(s): _____

Please answer the following clinical questions:

What type of cancer does the member have (include histology) and what stage disease?

_____

What is the member's chemotherapy regimen? _____

_____

What line of therapy is this considered (First, Second, Subsequent)? _____

What previous therapies has the member received? (Please include if the member progressed or relapsed) _____

_____

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745