CARE COORDINATORS
BY QUANTUM HEALTH

Chemotherapy/Radiation Precertification Questionnaire

THIS FORM MUST BE COMPLETED AND RETURNED FOR REQUEST TO BE REVIEWED. THE NCCN PAGE NUMBER AND SUBMISSION OF CLINICAL DOCUMENTATION MUST ACCOMPANY THIS COMPLETED FORM.

Date of Request: **Fax Form back to CHC at:**

Member Name:	**Date of Birth:**
Member ID:	**Referral #:**
Physician's Full Name:	**TIN:**
Office Location:	**Phone:**
Contact Person:	**Fax:**

Diagnosis:
Diagnosis codes:
Staging:

1. **Treatment To Date For This Diagnosis:**

2. **NCCN GUIDELINE OR TEMPLATE PAGE NUMBER:**
3. **Proposed Treatment Protocol:**

DRUG NAME or RADIATION TYPE	J CODE or CPT CODE	DOSAGE IN UNITS OF Mg/M2, Gy, or cGy	SCHEDULED DAYS/ # OF CYCLES	START DATE AND DURATION

4. **Is the proposed treatment plan consistent with NCCN Guidelines?** ☐ **YES** ☐ **NO**
5. **Are there any medication(s) to be used in the patient's treatment that are not FDA approved for the proposed purpose?**

   ☐ **YES** ☐ **NO**

   (If yes, specify the medication(s) and submit literature to support the request)

6. **Is the patient participating in a clinical trial or research study?** ☐ **YES** ☐ **NO**

   (If yes, completion of question six is required. A copy of the trial consent or protocol must accompany this request)

7. **NCT#**_____

SIGNATURE OF ORDERING PHYSICIAN OR PHYSICIAN'S AUTHORIZED REPRESENTATIVE: _____

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