Custom Design Benefits

Date of Request: ____/____/_____

CHEMOTHERAPY PRE-CERTIFICATION REQUEST

Patient Name: _____ **Member ID # _____**

Patient DOB: ____/____/_____ Patient Phone: (___) ____-_____ Different Last Name: _____

Ordering Physician: _____ Address: _____

City: _____ State: ____ Zip _____ Phone: (___) ____-_____ Fax: (___) ____-_____

Contact Person: _____ Fax: ( )____-____ Contact Phone: (___) ____-_____ Ext: _____

Physician Tax ID#: _____ NPI#: _____

FACILITY FOR SERVICE:

Fax: ( ) -

Name: _____ Phone: (___) ____-_____

Address, City, State: _____

Facility Tax ID: _____ Facility NPI#: _____

Please describe the proposed treatment protocol and list all related diagnoses (including metastases and staging for cancer treatment.) DX: _____

_____

Is the treatment plan consistent with NCCN Guidelines? Yes____ Page #_____ No_____

Drug Name	HCP or "J" Code	Dosage & Administration	Schedule/ # of Cycles	Start date and Duration

CONTINUED ON NEXT PAGE

Drug Name	HCP or "J" Code	Dosage & Administration	Schedule/ # of Cycles	Start date and Duration

Is the patient participating in a clinical trial or research study?

YES: _____ NO: _____

Is the treatment regimen/Protocol for this patient the subject of an IRB review or approval at your institution?

YES: _____ NO: _____

Any medication(s) to be used in this patient's treatment regimen that are NOT FDA approved for the proposed use?

YES: _____ NO: _____

PLEASE PROVIDE ALL CLINICAL DOCUMENTATION FOR PROCESSING.

FAX TO: MMFAX@CUSTOMDESIGNBENEFITS.COM OR FAX TO 513-389-2997

This authorization is not a guarantee of payment. Plan benefits are based on the patient's eligibility at the time of service. For questions on eligibility and benefits call 513-598-2929/800-598-2929

MM Form 2021