



CANCER PRIOR AUTHORIZATION REQUEST

Please Return this cover sheet and all required information to: Attn: Or g t c v k p c r i G h l e l e p e f

Fax: (406) 523-3101

**Mail: Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018**

Phone: (800) 877-1122

COMPLETED BY ORDERING PHYSICIAN:

Sent By: _____

Patient Name:	Patient Health Plan ID #:	Patient Date of Birth:
Provider Name:	Provider TIN:	Provider Phone: Provider Fax:
Request Date:		Scheduled Date:
ERV:		KEF/32'Eqf gr:

Inpatient

Outpatient

Please provide the following information:

1. Full pathology report.
2. Surgical operation report if applicable.
3. Full history and physical related to cancer diagnosis including the plan of treatment.
4. Flow sheets with documentation of chemotherapy given/ orders if not given.
5. All radiology reports related to cancer diagnosis.
6. Ongoing progress notes of physician.
7. Ongoing flow sheets and orders with documented chemotherapy / supportive medications.
8. Any other information deemed necessary to evaluate the pre-authorization request.

Upon receipt of all required information, the Plan will provide a written response to the written request for preauthorization. Please allow three (3) business days for a response.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information. Predeterminations are valid for 60 days from the issue date.