BlueCross BlueShield of Texas

Proton Beam Radiation Therapy Physician Worksheet

Fax completed forms to 877-361-7666

Requester Last Name:	Requester First Name:	
Telephone Number:	Fax Number:	
Is this the individual that should be contact if we have questions? ☐ Yes ☐ No		
If no, who should we contact?	Telephone Number:	
Provider Information		
Radiation Oncologist:		
Telephone Number:	TIN:	
Street Address:		
City:	State:	Zip Code:
Contact Last Name:	Contact First Name:	
Telephone Number:	Fax Number:	
Site Information		
Facility name:	TIN:	
Contact Last Name:	Contact First Name:	
Telephone Number:	Fax Number:	
Street Address:		
City:	State:	Zip Code:
Member Information		
Member Last Name:	Member First Name:	
Member Identification Number:	Group #:	DOB: ____ /____ /____
Street Address:		
City:	State:	Zip Code:

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Clinical Information

Anticipated therapy start date: ____ /____ /_____	End date: ____ /_____ /_____	ICD-9 code:

1.	What is the primary site?
	☐ Uveal melanoma ☐ Localized prostate cancer ☐ Other: _____ ☐ Chordoma/chondrosarcoma at base of skull or cervical spine ☐ Pituitary tumor ☐ Central nervous system tumor ☐ Pediatric radiosensitive tumor
1a.	If the primary site is the uveal melanoma, what is the diameter and height of the tumor?
	Tumor diameter: _____ mm Tumor height: _____ mm
1b.	If the primary site is the central nervous system tumor, please describe the histology in the space below:
2.	Does the member have distant metastatic disease? ☐ Yes ☐ No
3.	Is the member younger than 18 years of age? ☐ Yes ☐ No
4.	Where is the treatment being directed?
	☐ Primary site ☐ Metastatic site - fill in the site being treated: _____
5.	For which phase(s) will proton beam therapy be used?
	☐ Entire treatment ☐ Boost to conventional treatment
6.	Has this site received previous radiation therapy? ☐ Yes ☐ No
7.	Is the member being treated on a NCI registered clinical trial? *If yes, proceed to question #7a; if no, skip forward to question #8.* ☐ Yes ☐ No
7a.	What is the NCI trial number?

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8.	What is the member's ECOG performance status?	☐ 0 - Fully active, able to carry on all pre-disease performance without restriction.
		☐ 1 - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
		☐ 2 - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
		☐ 3 - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
		☐ 4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

9.	What are the CPT codes (77413-77416, 77418, 77520-77525) and number of fractions that will be rendered for each phase of treatment (fill in the table below)?			
		Phase 1	Phase 2	Phase 3
	How many fractions will be rendered for each phase of treatment?			
	Enter specific CPT codes from the list below that will be used for each phase: a. 77413 - 77416 (use 77416 as surrogate for any of these codes) b. 77418 c. 77520 - 77525			

10.	Please note any additional information below. Attach consultation note if available.