



Advanced Health
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Oncology Notification Form

Advanced Health OHP Dual Eligible (Medicare & Advanced Health OHP)

Plan ID# Today's Date

Member Name: DOB

Requesting Provider: Contact name:

Phone # Ext# Fax #

Requesting Provider NPI#:

Treatment Plan

H & P attached

Date treatment started

ICD-10 Code(s)

Medication(s) name (units not required)

This notification form will serve as authorization for members diagnosed with cancer, currently receiving treatment. This authorization will cover services performed by local contracted providers and will include MD visits, infusion services, labwork, medications, radiation treatments and will be valid for a six month period. A new form will be required for services beyond dates authorized. Periodic requests for clinicals may be necessary for ongoing case management purposes. Thank you.

For Internal Use Only:
Authorization Number
Dates authorization valid
Completed by Date