



Radiation Information Request Form

From _____	Phone _____
Reference number _____	Fax _____
Pages (including cover sheet) _____	Comments _____

Please see the information form below. This information is required in order to review the requested procedure against the medical policy. The information will assist us in providing a timely determination of coverage for your patient's request.

An accurate decision cannot be made without this information. Please complete document or ensure clinical includes information noted below and upload to the New York City Employees PPO (NYCE PPO) portal at nyceppo.com.

UnitedHealthcare policies can be viewed in detail at: [UnitedHealthcare Commercial Medical & Drug Policies](#)

Patient name _____	Patient date of birth _____ <small>MM/DD/YYYY</small>
Date of initial diagnosis _____	
Cancer site (Please fill out as applicable)	
• Primary site _____	
• Secondary site _____	
• Other metastatic sites _____	
Radiation target site _____	
Staging information _____	
For breast cancer (check appropriate)	
ER	Positive Negative PR Positive Negative
HER2	Positive Negative

Please check modality being requested

Intensity-modulated radiation therapy (IMRT)

External beam radiation therapy (EBRT)

3D conformal

Proton beam

Brachytherapy

Stereotactic radiosurgery (SRS)

Stereotactic body radiation therapy (SBRT)

Image-guided radiation therapy (IGRT)

Neutron beam

Intraoperative

If IMRT is being requested, please upload color histograms to your portal at nyceppo.com.

If IMRT is being requested for breast cancer, please check the appropriate indication:

When the left-sided internal mammary nodes are being treated

Accelerated partial breast irradiation of up to 5 fractions

Treatment/dosage regimen requested

- Gy/cGy _____
- Number of fractions requested _____
- Requested date range _____

Please include any prior and adjunctive treatments in clinicals sent for medical review i.e., chemotherapy, hormonal treatments, surgeries.