



Pre-Certification / Pre-Authorization Form for Cancer Clinical Trials

Instructions to providers: Please complete all of the information below. For health plans and insurers, check to see if you will need more information based on the patient's benefits.

ATTENTION: Cancer Clinical Trial Review-please complete and fax back to me as soon as possible. This patient is waiting to start treatment.

To: Integrated Health Management Fax #: (651) 662-2810

Health plan: CCStpa

From: Phone: FAX:

Date:

Re: Notification for Participation in Cancer Clinical Trial

Patient Name:

Group ID #: Member #:

Health plan contract # (if available):

Treating Physician:

Treating Site: (Include: street address, city, and state)

Clinical Trial Sponsor: Study #:

Primary Diagnosis:

On behalf of the above treating physician, I am submitting prior notification of this patient's intended treatment within the above clinical trial. Please complete and return to me.

TO BE COMPLETED BY HEALTH PLAN AND FAXED BACK TO SENDER

(SPECIFY):

Fully insured - standard care costs may be billed to health plan according to the health plan's clinical trial policy

Self-insured - need the following additional information faxed for authorization

Self-insured - standard care costs may be billed to health plan according to the health plan's clinical trial policy

CASE NUMBER: CONTACT/FAX # to send:

Signature, Health plan contact

Date

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