Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

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 # _________________________________

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_____________