

Phone: 1 (888) 333-9036

Fax: 1 (888) 785-2487

PET SCAN PRECERTIFICATION FAX FORM

Date: _____

From: _____
(Physician or Practice Name)

Patient's Name: _____

Patient's Address: _____
(Street, City, State, Zip)

Patient's Contract Number: _____

Patient's Date of Birth: _____

Please check the box/boxes this fax pertains to:

- Initiating a New Precertification Request
- Providing Written Clinical Certification Notes
- Providing **Additional** Clinical Information (for Review in Progress)
- Appeal _____
- Other _____

The following information will assist CareCore in completing your request more efficiently:

- Relevant Medical Records and/or Results of Prior Imaging
- Clinical Office and/or Consultation Notes
- Signed and Dated Clinical Summary Documenting Indications for This Examination(s)

Fax completed PET Scan Precertification Fax Forms to CareCore National, LLC at 888-785-2487.

You may retain a blank copy of the request form for future use.

Number of Pages: _____

CONFIDENTIALITY NOTICE: The attached information to this facsimile transmission is **CONFIDENTIAL** and is intended only for the use of the recipient(s) identified above. It may contain confidential and protected health information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are not the intended recipient or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is **STRICTLY PROHIBITED**. If you have received this transmission in error, please notify me immediately by telephone and destroy the transmission and its attachments without saving them in any manner.

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Precertification Request Form

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PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED COMPLETELY. FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST.

Patient Name _____ DOB _____

Insurance Plan _____ Subscriber ID _____

Referring Physician _____ Physician ID _____

Physician Address _____ City _____ State _____

Physician Fax #(____) _____ Phone #(____) _____

Date of Request _____ Contact Person _____

Imaging Facility Name _____ Site Phone #(____) _____

Site Address _____ City _____ State _____

Please circle the CPT or G code you are requesting:

78811	PET, limited	78816	PET with CT, whole body
78812	PET, skull base to mid thigh	78459	Myocardial imaging, PET, metabolic
78813	PET, whole body	78491	Myocardial imaging, PET, single study
78608	Brain imaging, PET metabolic evaluation	78492	Myocardial imaging, PET, multiple studies
78609	Brain imaging, PET perfusion evaluation	G0219	PET, whole body for melanoma
78814	PET with CT, limited	G0252	PET, breast cancer
78815	PET with CT, skull base to mid thigh	G0235	PET, Unlisted
		S8085	Fluorine-18 Fluorodeoxyglucose dual head

Cell type or tissue diagnosis and date of diagnosis _____ Stage _____

Reason for Study: Initial Staging _____ Restaging _____ Suspected Recurrence _____
 Surveillance _____ Evaluation for Biopsy Site _____

Other Rationale for This Examination _____

Prior Imaging results (include type of examination and dates) _____

Current tumor markers and date _____

Most recent past tumor markers and date _____

Liver function tests _____ Alkaline Phosphatase _____

Current symptoms _____

Patient Name: _____ Patient ID: _____

Current findings on physical examination _____

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Currently on Chemotherapy Yes No

Completed Chemotherapy Yes No Date _____

Current Radiotherapy Yes No

Completed Radiotherapy Yes No Date _____

Surgery Yes No Date _____

If yes, please explain. _____

Known Metastatic Disease: Yes No If yes, please check all that apply:

Liver Lung Bone Brain Ovary Spleen Pancreas Kidney Bowel Spine

Lymph nodes involved:

Cervical Axillary Supraclavicular Hilar Mediastinal Retroperitoneal

Celiac Pelvic Porta Hepatis Iliac Inguinal Other

How will the results of this test influence patient management? _____

Other Pertinent Information _____

Signature of Requesting Physician

Date