Breast Cancer PET/CT Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. to 888.693.3210. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Requests may also be submitted via the web at eviCore.com. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE TO 800.440.5071.**

Patient/Member

First Name:	Middle Initial:	Last Name:
DOB (*mm/dd/yyyy*):		Gender: ◯ Male ◯ Female
Street Address:		Apt #:
City:	State:	Zip:
Home Phone:	Cell Phone:	Primary Contact: ◯ Home ◯ Cell
Health Plan:	Member ID:	

Ordering Provider

First Name:	Last Name:	Medicaid ID:
Primary Specialty:	TIN:	NPI:
Physician Phone:	Physician Fax:	
Address:		Suite #:
City:	State:	Zip:
Office Contact:		Ext:
Contact Email:		

Facility/Site

First Name:	Last Name:	
Group/Site Name:	Medicaid ID:	
Primary Specialty:	TIN:	NPI:
Site Phone:	Site Fax:	
Address:		Suite #:
City:	State:	Zip:

Procedure

This form is for PET or PET/CT requests only. Diagnostic CT scans should be requested separately.

Check all applicable CPT Codes:	☐ 78811	☐ 78812	☐ 78813	☐ 78814
	☐ 78815	☐ 78816	☐ Other:	

Diagnosis

Diagnosis, if known or rule out:
ICD-10 Codes:
Date of last visit:

Clinical Information

1. Does the requested imaging meet a requirement for a clinical trial protocol?

- ◯ NCI sponsored clinical trails (Clinical Trial Number):
- ◯ Industry sponsored clinical trial
- ◯ Does not qualify for a clinical trial protocol
- ◯ Don't Know

2. Has cancer diagnosis been confirmed by biopsy? ◯ Yes ◯ No ◯ Don't Know

3. Is the tumor 5cm or greater in size? ◯ Yes ◯ No ◯ Don't Know

4. Is neoadjuvant therapy planned? (neoadjuvant therapy is treatment given as a first step to shrink a tumor before the main treatment, which is usually surgery) ◯ Yes ◯ No ◯ Don't Know

5. Is there documented lymph node involvement? ◯ Yes ◯ No ◯ Don't Know

6. If lymph node is involved, how many?

- ◯ Less than 4
- ◯ Greater than or equal to 4
- ◯ Not Applicable
- ◯ Don't Know

7. Has treatment started? ◯ Yes ◯ No ◯ Don't Know

8. Has three months lapsed since completion of radiation therapy? ◯ Yes ◯ No ◯ Don't Know ◯ No Treatment

9. Is there known metastatic disease? ◯ Yes ◯ No ◯ Don't Know

Additonal Information/Comments:

Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: