

Breast Cancer PET/CT Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. 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	
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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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	Not Applicable		
	Greater than or equal to 4	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	
Additional Information/Comments:				
Submitter	Who is making this request? Ordering Physician Facility Other:			
	Print Name:			
	Title: MD RN LPN PA NP Other:			
	Signature:			Date: