

## Cervical 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](http://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		<b>This form is for PET or PET/CT requests only. Diagnostic CT scans should be requested separately.</b>				
	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:					

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**Clinical Information**

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

NCI sponsored clinical trials (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. What is the stage?

Less than or equal to 1B1 (tumor size less than 4cm that is confined to the cervix)

Greater than or equal to 1B2

Don't Know

4. Has there been surgical resection? Yes      No      Don't Know

5. Is there evidence of recurrence on physical exam? Yes      No      Don't Know

6. Has radiation therapy been completed within the last 3 months? Yes      No      Don't Know

7. Is salvage surgical resection an option? 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: