

Lymphoma 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 HC, \$\$Y (\$') \$+%**

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-9 or 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 cell type?

Diffused large cell

CLL/SLL (Chronic Lymphocytic Leukemia/ Small Lymphocytic Lymphoma

Follicular

Don't Know

Hodgkins

Other:

4. Has treatment started? Yes No Don't Know

5. Have 3 months lapsed since completion of radiation therapy? Yes No Don't Know

No Treatment

Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: