

## Ovarian Cancer PET/CT Imaging Request

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. At the time of fax, 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 'HC', '\$\$( (\$) \$+%**

<b>Patient/Member</b>	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:			
	<b>Ordering Provider</b>	First Name:		Last Name:		Medicaid ID:
Primary Specialty:		TIN:	NPI:			
Physician Phone:			Physician Fax:			
Address:				Suite #:		
City:			State:	Zip:		
Office Contact:					Ext:	
Contact Email:						
<b>Facility/Site</b>		First Name:			Last Name:	
	Group/Site Name:			Medicaid ID:		
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
	<b>Procedure</b>	<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:		
<b>Diagnosis</b>	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

**CONFIDENTIALITY NOTICE:** This fax transmission, and any documents attached to it may contain confidential or privileged information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information is intended only for the use of the recipient (s) named above. 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 immediately notify eviCore healthcare and destroy the original transmission and its attachments without saving them in any manner.

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. Is the individual symptomatic? Yes No Don't Know

3. Has recent CT/MRI imaging been negative or equivocal? Yes No Don't Know

4. Is the CA-125 level increasing? (CA-125 is a lab test) 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: