

## Pancreatic 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.**

<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		78811	78812	78813	78814	
CPT Codes:		78815	78816	Other:		
<b>Diagnosis</b>	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. Has there been any other imaging? Yes No Don't Know

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

5. Is surgical resection planned or being considered? Yes No Don't Know

6. Has radiation therapy been completed in the past 3 months? 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: