



## **Solitary Pulmonary Nodule 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 TO 800.440.5071.

Patient/Member	First Name:		Middle Initial:	Last Name:					
	DOB ( <i>mm/dd/yyyy</i> ):			Gender:	Male Female				
	Street Address:				Apt #:				
	City:			State:	Zip:				
	Home Phone:		Cell Phone:		Primary Contact: Home Cell			Cell	
	Health Plan:		Member ID:						
Ordering Provider	First Name:		Last Name:		Medicaid ID:				
	Primary Specialty:		TIN:		NPI:				
	Physician Phon	ne:	Physician Fax	an Fax:					
	Address:				Suite #:				
	City:			State:	Zip:				
	Office Contact:			Ext:					
	Contact Email:								
-									
	First Name:			Last Name:					
ite	First Name: Group/Site Nar	ne:		Last Name: Medicaid ID:					
ty/Site			TIN:	ł	NPI:				
cility/Site	Group/Site Nar		TIN:	ł	NPI:				
Facility/Site	Group/Site Nar Primary Specia		TIN:	Medicaid ID:	NPI: Suite #:				
Facility/Site	Group/Site Nar Primary Specia Site Phone:		TIN:	Medicaid ID:	I				
	Group/Site Nar Primary Specia Site Phone: Address: City:			Medicaid ID: Site Fax: State:	Suite #: Zip:	equested s	eparatel	y.	
	Group/Site Nar Primary Specia Site Phone: Address: City: This form Check all	ılty:	equests only. Diagno	Medicaid ID: Site Fax: State:	Suite #: Zip:	equested s	eparatel	y.	
Procedure Facility/Site	Group/Site Nar Primary Specia Site Phone: Address: City: This form	is for PET or PET/CT re	equests only. Diagno	Medicaid ID: Site Fax: State: State:	Suite #: Zip: should be re	equested s	separatel	y.	
Procedure	Group/Site Nar Primary Specia Site Phone: Address: City: <b>This form</b> Check all applicable CPT Codes:	is for PET or PET/CT re 78811	equests only. Diagno	Medicaid ID: Site Fax: State: State: 78813	Suite #: Zip: should be re	equested s	separatel	y.	
	Group/Site Nar Primary Specia Site Phone: Address: City: <b>This form</b> Check all applicable CPT Codes:	is for PET or PET/CT ro 78811 78815 nown or rule out:	equests only. Diagno	Medicaid ID: Site Fax: State: State: 78813	Suite #: Zip: should be re	equested s	separatel	y.	

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Clinical Information	1. Does the requested imaging meet a requirement for a clinical trail 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 a chest-CT been done to diagnose SPN (Solitary Pulmonary Nodule)?	Yes	No	Don't Know					
	If yes, what was the date?								
	3. Was the SPN initially found on a study other than a Chest CT?	Yes	No	Don't Know					
	4. Is there a history of cancer?	Yes	No	Don't Know					
	5. Is this nodule, mass or lesion 7mm or larger?	Yes	No	Don't Know					
	6. Has a prior PET scan been done for this SPN?	Yes	No	Don't Know					
	7. Has the nodule been stable for 2 years or more?	Yes	No	Don't Know					
	8. What is the size of the SPN?								
	7mm to 1cm Great	er than 4cm							
	1cm to 4cm Don't	Know							
	Additonal Information/Comments:								
=									
Submitter	Who is making this request? Ordering Physician Facility Other:								
	Print Name:								
	Title: MD RN LPN PA NP Other:								
Su									
	Signature:	Date:							

Page 2 of 2