

Colon Cancer PET/CT Imaging Request



For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. 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. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

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:		Group ID:	
Ordering Provider	First Name:			Last Name:		
	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:					
	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-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 colorectal cancer been confirmed by biopsy or surgery?	Yes	No	Don't Know
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3. Is there documented lymph node involvement?	Yes	No	Don't Know
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4. Was the tumor contained within a polyp?	Yes	No	Don't Know
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5. Has radiation or chemo therapy been done within the last 3 months?	Yes	No	Don't Know
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6. Is CEA or LFT's elevated (CEA = Carcinoembryonic Antigen; LFT = Liver Function Test)	Yes	No	Don't Know
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7. Was there a CT or MRI recently ordered?	Yes	No	Don't Know
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8. Is there known metastatic disease?	Yes	No	Don't Know
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Additonal Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: