# Head and Neck 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: |

## 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. Is there documented lymph node involvement? | ◯ Yes | ◯ No | ◯ Don't Know |
| 4. Is this PET needed to identify the primary site of cancer? | ◯ Yes | ◯ No | ◯ Don't Know |
| 5. Has treatment started? | ◯ Yes | ◯ No | ◯ Don't Know |
| 6. Has radiation therapy been done within the last 3 months? | ◯ Yes | ◯ No | ◯ Don't Know |
| 7. Is this PET scan to evaluate the recurrence of cancer? | ◯ Yes | ◯ No | ◯ 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:

Signature: Date: