Lymphoma 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-9 or 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. What is the cell type?

- ◯ Diffused large cell
- ◯ CLL/SLL (Chronic Lymphocytic Leukemia/ Small Lymphochytic Lymphoma
- ◯ Follicular
- ◯ Don't Know
- ◯ Hodgkins
- ◯ Other:

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

5. Have 3 months lapsed since completion of radiation therapy? ◯ Yes ◯ No ◯ Don't Know ◯ No Treatment

Additonal Information/Comments:

Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: