

# Ovarian 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](http://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.**

<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:		Group ID:	
	<b>Ordering Provider</b>	First Name:			Last Name:	
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:					
	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 CPT Codes:		78811	78812	78813	78814	
		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. Is the individual symptomatic? Yes No Don't Know

3. Has recent CT/MRI imaging been negative or equivocal? Yes No Don't Know

4. Is the CA-125 level increasing? (CA-125 is a lab test) 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: